

MENTAL HEALTH & HIGH SCHOOL CURRICULUM GUIDE

UNDERSTANDING MENTAL HEALTH & MENTAL ILLNESS

WALES VERSION 2018



HOW |
ACTION FOR CHILDREN
SUT MAE | WORKS
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September 2018

This version of the Mental Health & High School Curriculum Guide is based upon the third version of the Mental Health and High School Curriculum Guide developed by Dr Stan Kutcher and TeenMentalHealth. Action for Children have been commissioned on behalf of the Welsh Government to deliver these adaptations in association with Dr Stan Kutcher and TeenMentalHealth.

The Welsh adaptation can be found at: www.actionforchildren.org.uk/TheGuide

The password to access the Welsh resources is: GuideCymru

The original version can be found at: <http://teenmentalhealth.org/curriculum/>

The password to access the original materials is: **t33nh3alth**

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Our thanks to Andrew Baxter (Alberta Health Services) and the scores of teachers, principals and other educators who provided feedback based on their application of the second edition of this resource.

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Introduction

About the Guide

The Mental Health and High School Curriculum Guide (the Guide) is the only evidence-based mental health curriculum resource that has been demonstrated to improve both teachers' and pupils' mental health literacy through usual teacher education and application in the classroom in a variety of programme evaluations and research studies in Canada and elsewhere.*

This edition of the Guide replaces previous versions and has been rewritten with new materials added and reflects Diagnostic and Statistical Manual V (DSM-5) nomenclature. The Guide is available online with all components found in this book easily accessible using the password found on page 2. The online version of the Guide can be obtained at: www.actionforchildren.org.uk/TheGuide

Information about how to access training programmes related to the use of the Guide can be found at www.actionforchildren.org.uk/TheGuide

In addition to the online version and supporting materials for the Guide, the website <http://teenmentalhealth.org/> provides a rich repository of materials that can be used by educators and pupils alike in improving their understanding of mental health and mental disorders.

The Guide has been developed to help enhance the mental health literacy of pupils and is targeted to be used in grades eight, nine and ten (ages 13 to 15 years). The Welsh adaptation is designed to be implemented with year 9 pupils (age 14-15). This is the time of the lifespan in which the diagnoses of mental disorders begins to increase dramatically; it is thus essential that young people be able to have the knowledge, attitudes and competencies to help themselves and others if necessary. Mental health literacy has four components:

- 1) Understanding how to optimise and maintain good mental health
- 2) Understanding mental disorders and their treatments
- 3) Decreasing stigma
- 4) Enhancing help-seeking efficacy (knowing when and where to get help and having the skills necessary to promote self-care and how to obtain good care)

The Guide helps prepare pupils for success in each of these domains. Educators using the Guide may wish to use additional information to supplement the resources described in the Guide or to increase their knowledge in youth mental health. While there are many mental health resources available, we recommend one that meets our standards of quality: the classroom resource "Stop Wondering, Start Knowing" which can be found at <http://keltymentalhealth.ca>.

*Reports from some of the programme evaluations and research on the application of the Guide can be found online at: <http://teenmentalhealth.org/toolbox/>.

Introduction

Using the Guide

This section provides general information about the Guide and suggestions for its classroom application.

Purpose:

The Guide is intended to be used by classroom teachers who have been trained in its application to enhance the mental health literacy of pupils in year nine.

Structure:

The Guide consists of both teacher preparation and classroom ready materials that can be easily accessed from the web at www.actionforchildren.org.uk/TheGuide using the password found on page 2.

The steps to implement the Guide are:

- Step 1)** Pre/Post-Quiz
- Step 2)** Teacher Knowledge Update
- Step 3)** Modules

Pre/Post Quiz:

The purpose of this component is to help facilitate self-study for the teacher prior to applying the Guide in the classroom. Taking the Pre-Quiz will help you identify areas in which your knowledge base needs enhancement. After taking the Pre-Quiz, keep a record of those questions that you have answered incorrectly. Then read the Teacher Knowledge Update and pay particular attention to finding the information related to the questions that you answered incorrectly. Take the Post-Quiz upon reading the Teacher Knowledge Update. If you have answered any questions in the Post-Quiz incorrectly please return to the Teacher Knowledge Update and review the section(s) therein that relate to the questions you answered incorrectly.

Teacher Knowledge Update (Fundamental):

The purpose of this component is to provide basic information about mental health and mental disorders that will help the teacher better apply the Guide resource in the classroom. A more comprehensive resource, Teacher Knowledge Update (Enhanced), can be found at www.actionforchildren.org.uk/TheGuide

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Modules:

The purpose of this component is to provide teachers with classroom ready lesson plans, activities and easily accessible resources to assist them in applying the Guide. The six modules are designed to be taught in sequence. All modules have two sections: Core Materials and Supplementary Materials. The Core Materials are designed to be used for all pupils and are required to be taught in the classroom so as to achieve the outcomes identified in the research and evaluation of this resource. The Supplementary Materials are designed for use by pupils who want to spend additional time and effort to learn more about the module topic. Teachers are encouraged to use their discretion in the introduction of the Supplementary Materials in their classes. Teachers should familiarise themselves with BOTH the Core Materials and Supplementary Materials and decide if and how they will introduce the Supplementary Materials in their classrooms once the Core Materials have been taught.

Format of the modules:

As you review the modules, you will find that each one includes several key features:

- The **Overview** provides a summary of the module.
- The **Learning Objectives** list specific understandings or competencies pupils should derive from completing the modules.
- The **Major Concepts** section presents the central ideas that the module is designed to address.
- **Teacher Background** provides ideas about suggested information that should be reviewed prior to teaching the module to enhance your understanding of the content so that you can confidently facilitate class discussions, answer pupils' questions and provide additional examples and illustrations.
- The **Activities** section provides details about suggested classroom application. Teachers are encouraged to use as many of the activities in each section as possible.
- The **Required Materials** section provides resources needed to complete the activities in each module.
- The **In Advance** section provides instructions for collecting and preparing materials required to complete the activities in the module.
- **Notes to Teachers** appear as sidebars. Look here for information about issues that may need to be emphasised.

The Guide and Existing School Curriculum:

The Guide is not meant to replace existing school curriculum. It is meant to be a classroom resource applied by usual classroom teachers that can be used within existing curriculum frameworks to enhance the mental health literacy of both pupils and teachers. Research on various strategies in classroom application of the Guide has identified that optimal results can be obtained by training teachers on how to apply the Guide in their classrooms, teaching the Guide as part of a curriculum component (within an appropriate subject area such as Health and Physical Education, Personal Development, Family Studies, etc.) and teaching the Guide as a block (six modules taught consecutively over a period of 8 to 12 hours).

Introduction

The modules were designed to each fit into 60 minutes of classroom time. Based on feedback from teachers and pupils, Module 3 of the Guide is the longest and most information intense module and may require more teaching time than other modules. We recommend that 1.5-2, 50-minute blocks be allocated to Module 3.

Resources in the Guide:

The Guide provides the teacher with resources meant to engage the student in their learning, be interactive, experiential, to stimulate critical thinking and personal reflection and to help stimulate a search for knowledge. This resource includes printed materials, animated videos, PowerPoint presentations and web-downloadable materials. Interactive teaching tips and suggestions for guided discussion are also provided.

Teachers are free to use other resources that they think will be appropriate. However, some resources are more reliable and accurate than others, therefore we have created a “Guide Project Governance Committee” to suggest and assure the resource content is valid for use in the classroom. These resources have undergone extensive professional review and are known to be both up to date and consistent with best available scientific knowledge. They are periodically updated and posted on the website. The developers of the Guide do realise that there are other sources of information about mental health and mental disorders available and have identified some credible and trustworthy websites in the section “Further Resources and Information about the Guide”. We suggest that teachers use the Guide resources as they appear in each module and supplement these with other materials obtained from those websites that we have identified to ensure as much as possible that valid and appropriate information is used in the classroom.

Some of the modules lend themselves to the use of resources from outside the classroom or the school. For example, in-school student services professionals (such as psychologists or social workers) or health and human services professionals from community agencies (such as physicians, psychologists, social workers, substance abuse specialists, etc.) may be able to add invaluable input into what pupils are learning (for example, in Module Five addressing help-seeking). In some schools, organised speakers from credible Organisations (e.g. the NHS) may be available to provide additional inputs. Teachers choosing to employ these resources should ensure that the person addressing the class belongs to a responsible and credible Organisation or institution and that the presenter understands what the goals and expected outcomes of their presentation are meant to be.

Introduction

Reviewing the Guide

Module	Major Concepts
<p>Module 1: The stigma of mental illness</p>	<ul style="list-style-type: none"> • Stigma acts as a barrier to people seeking help for mental health problems and mental illness. • Understanding mental illness and treatments can help dispel misconceptions and stigma. • People’s attitudes about mental illness can be positively influenced by exposure to accurate information. • We all have a responsibility to fight the stigma associated with mental illness.
<p>Module 2: Understanding mental health and mental illness</p>	<ul style="list-style-type: none"> • Everyone has mental health regardless of whether or not they have a mental illness. • The brain controls our thinking, perceptions, emotions, physical activities, behaviour and provides us with cues about how to adapt to our environment (signaling). • A mental illness is a health condition arising from changes in usual brain functioning that causes that person substantial difficulty in functioning. • Mental illnesses have complex causes that include a biological basis and are therefore not that different from other illnesses. As with all illnesses, the sooner people obtain effective treatment for mental illness - the better their outcomes. • The stress response is a normal phenomenon that signals adaptation to changes in our environment is needed.
<p>Module 3: Information on specific mental illnesses</p>	<ul style="list-style-type: none"> • All mental illnesses reflect difficulties in: thinking, perception, emotions, physical activities, behaviour and signaling. • The exact cause of mental illnesses is not yet known, but complex interactions between a person’s biology and their environment are involved. • Like illnesses that affect other parts of the body, mental illnesses are treatable and the sooner people receive proper treatment and support, the better the outcomes.
<p>Module 4: Experiences of mental illness</p>	<ul style="list-style-type: none"> • Mental illnesses are diseases that affect many aspects of a person’s life. • With appropriate support and receipt of evidence-based treatment, most people with a mental illness can function effectively in everyday life. • Getting help early increases the chances that a person will make a full recovery from mental illness. • Mental illnesses, like physical illnesses, can be effectively treated.

Introduction

Module	Major Concepts
Module 5: Seeking help and finding support	<ul style="list-style-type: none">• There are many ways of seeking help for mental health problems and mental illnesses, and resources are available within schools and within the community.• Knowing the signs and symptoms of mental illness helps people know how to distinguish the normal ups and downs of life from something more serious.• Recovery from mental illness is possible when a range of supports beyond formal treatment are available.• Everyone has mental health that can be supported and promoted, regardless of whether or not they also have a mental illness.
Module 6: The importance of positive mental health	<ul style="list-style-type: none">• Positive coping strategies can help everyone maintain and enhance their mental health.• There are skills and strategies that we can learn to help us obtain and maintain good mental health.

Teacher Knowledge Update

Teacher Knowledge Update (Fundamental)

This handbook is both part of this Guide resource and available separately on the **Action for Children** website at the direct URL: **www.actionforchildren.org.uk/TheGuide**

It is meant to be used by classroom teachers for two purposes. The first purpose is for teachers to study the material in the handbook before they apply the modules in their classrooms so that they can upgrade their knowledge about mental health and mental disorders. The second purpose is that this handbook can be used as a supplementary resource for pupils to use in Module Three. Teachers can make this easily available to their pupils either by providing them with the website link or by photocopying the PDF and placing the hard copy in the classroom – or both!

Remember, teachers are using this handbook to support their application of the Guide resource in their classroom teaching. This is being done to improve the mental health literacy of pupils. This handbook is not to be used to support the delivery of diagnosis or treatment recommendations for pupils or parents.

The role of the teacher does not include diagnosis or treatment recommendations. It does include teaching of mental health literacy, responding to pupils'/parents' concerns by supportive listening and referral to the most appropriate person within the school to help address those concerns (such as a counsellor, social worker, psychologist) and providing ongoing academically appropriate support to the student as part of the school's integrated response to the student's needs.

Using the Handbook for Self-Study:

Step 1: Before reading the Teacher Knowledge Update, take the self-evaluation Pre-Quiz (30 questions) and answer each question as True or False. Keep a record of the questions for which you provided the wrong answer to make sure that you cover those areas when you read the Teacher Knowledge Update.

Step 2: Carefully read the Teacher Knowledge Update, paying particular attention to areas in which your Pre-Quiz answers were not correct.

Step 3: Take the Post-Quiz (repeat of the Pre-Quiz). If you have any wrong answers in the Post-Quiz please go back to the relevant section of the Teacher Knowledge Update and make sure you have mastered the material there. Once you have all the answers correct you are ready to proceed to the use of the Guide materials as found in the Modules.

The password needed to access the Modules is: GuideCymru

Note: The Guide resource has been extensively researched (see page 161 for some recent publications) and has demonstrated significant and substantial positive impact on improving teachers' and pupils' knowledge and decreasing stigma. This research however is based on applying a training program for teachers to take prior to applying the Guide resource in their classrooms. If your school, or a school in your area would like to obtain the training please contact us at: **theguide@actionforchildren.org.uk**

Pre/Post Quiz

1. A phobia is an intense fear about something that might be harmful (such as heights, snakes).
a. True b. False
2. Useful interventions for adolescent mental disorders include BOTH psychological and pharmacological treatment.
a. True b. False
3. Mental distress can occur in someone who has a mental disorder.
a. True b. False
4. Stigma against the mentally ill is uncommon in Wales.
a. True b. False
5. Substance abuse is commonly paired with a mental disorder.
a. True b. False
6. The most common mental disorders in teenage girls are eating disorders.
a. True b. False
7. The stresses of being a teenager are a major factor leading to adolescent suicide.
a. True b. False
8. Three of the strongest risk factors for teen suicide are: romantic breakup, conflict with parents, and school failure.
a. True b. False
9. Schizophrenia is a split personality.
a. True b. False
10. A depressed mood that includes a drop in school grades and lasts for a month or longer in a teenager is very common and should not be confused with a Clinical Depression that may require professional help.
a. True b. False
11. A Generalised Anxiety Disorder usually arises from being burned out by stressful events.
a. True b. False

Pre/Post Quiz

12. Diet, exercise and establishing a regular sleep cycle are all effective treatments for many mental disorders in teenagers.
a. True b. False
13. Anorexia nervosa is very common in teenage girls.
a. True b. False
14. Bipolar Disorder is another name for manic depressive illness.
a. True b. False
15. The panic attacks that occur as part of Panic Disorder usually come “out of the blue”.
a. True b. False
16. Obsessions are thoughts that are unwanted and known to be incorrect.
a. True b. False
17. Serotonin is a liver chemical that helps control appetite.
a. True b. False
18. Mental disorders affect 1 in 4 adults in the UK.
a. True b. False
19. Young people who have Social Anxiety Disorder do not get well with treatment.
a. True b. False
20. Depression affects about 2 percent of people in the UK.
a. True b. False
21. A psychiatrist is a medical doctor who specialises in treating people who have a mental illness.
a. True b. False
22. Attention Deficit Hyperactivity Disorder (ADHD) is equally common in boys and girls.
a. True b. False

Pre/Post Quiz

23. A hallucination is defined as a sound that comes from nowhere.
a. True b. False
24. Panic Disorder is a type of Anxiety Disorder.
a. True b. False
25. Medications called “anti-psychotics” are helpful in treating some of the symptoms of Schizophrenia.
a. True b. False
26. A delusion is defined as seeing something that is not real.
a. True b. False
27. Lack of pleasure, hopelessness and fatigue can all be symptoms of a Clinical Depression.
a. True b. False
28. Nobody with Schizophrenia ever recovers to the point where they can live a positive life.
a. True b. False
29. People with Mania may experience strange feelings of grandiosity.
a. True b. False
30. Mental disorders are psychological problems that are often caused by poor nutrition.
a. True b. False

(See answer key end of this section)

Pre/Post Quiz Answers

- | | | | |
|-----|-------|-----|-------|
| 1. | True | 16. | True |
| 2. | True | 17. | False |
| 3. | True | 18. | True |
| 4. | False | 19. | False |
| 5. | True | 20. | False |
| 6. | False | 21. | True |
| 7. | False | 22. | False |
| 8. | False | 23. | False |
| 9. | False | 24. | True |
| 10. | False | 25. | True |
| 11. | False | 26. | False |
| 12. | False | 27. | True |
| 13. | False | 28. | False |
| 14. | True | 29. | True |
| 15. | True | 30. | False |



Teacher Knowledge Update



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What are Mental Disorders?*

* Please note that we will use the phrases mental disorder and mental illness as synonyms.

Here's what we know about mental disorders:

- Disturbances of emotion, thinking, and/or behaviour
- Derive from perturbations in the function of various brain circuits
- Arise from a complex interplay between genetic and environmental factors
- May range in intensity
- Lead to functional impairment (interpersonal, social, vocational, etc.)
- Respond to evidence-based treatments provided by trained professionals

Mental disorders are not:

- The consequence of poor parenting or bad behaviour
- The result of personal weakness or deficits in personality
- The manifestation of malevolent spiritual intent
- Caused by poor nutrition
- Poverty or lifestyle choices

How is the brain involved?

- Everything that a person does, feels, thinks or experiences involves the functioning of their brain
- Most things a brain does depends on many different parts of the brain working together in a network
- The brain is made up of cells, connections amongst the cells and various neurochemicals
- The neurochemicals provide a means for the different parts of the brain to communicate

The Functions of the Brain

Thinking or
Cognition

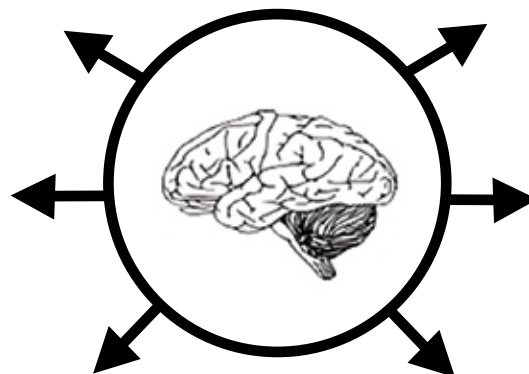
Behaviour

Perception
or Sensation

Physical
or Somatic

Emotion
or Feeling

Emotional Response
(being responsive and
reacting to the environment)



What happens inside the brain when it is not functioning effectively?

- A specific part of the brain that needs to be working in a specific manner is not working well
- A specific part of the brain that needs to be working in a specific manner is working in the wrong way
- Brain pathways that help different parts of the brain communicate are not working as they should

How does the brain show it's not working well?

- If the brain is not working properly, one or more of its functions will be disturbed
- Disturbed functions that a person directly experiences (such as sadness, sleep problems, etc.) are called symptoms
- Disturbed functions that another person sees (such as overactivity, withdrawal, etc.) are called signs
- Both signs and symptoms can be used to determine if the brain may not be working well
- The person's usual life or degree of functioning is disrupted because of these signs and symptoms

Mental disorders are associated with disturbances in six primary domains of brain function:

- Thinking
- Perception
- Emotion
- Emotional Response
- Physical
- Behaviour

Each of these brain functions is the result of millions of cells (neurons) communicating with each other through various circuits, using various chemical messengers called neurotransmitters (e.g. serotonin, dopamine, etc.). When the brain is not functioning properly in one or more of its six domains, and the person experiences problems that interfere with their life in a significant way, these circuits are disrupted and the person may develop the signs and symptoms of a mental disorder.

Mental disorders are characterised by perturbations in these brain functions, but not all changes in these functions signify a mental disorder. For example, negative emotions are a characteristic of many mental disorders, but most negative emotions are not the result of a mental disorder. Some can be a normal or expected response to the environment – for example: grief when somebody dies or acute worry, sleep problems and emotional tension when faced with a natural disaster such as a hurricane.

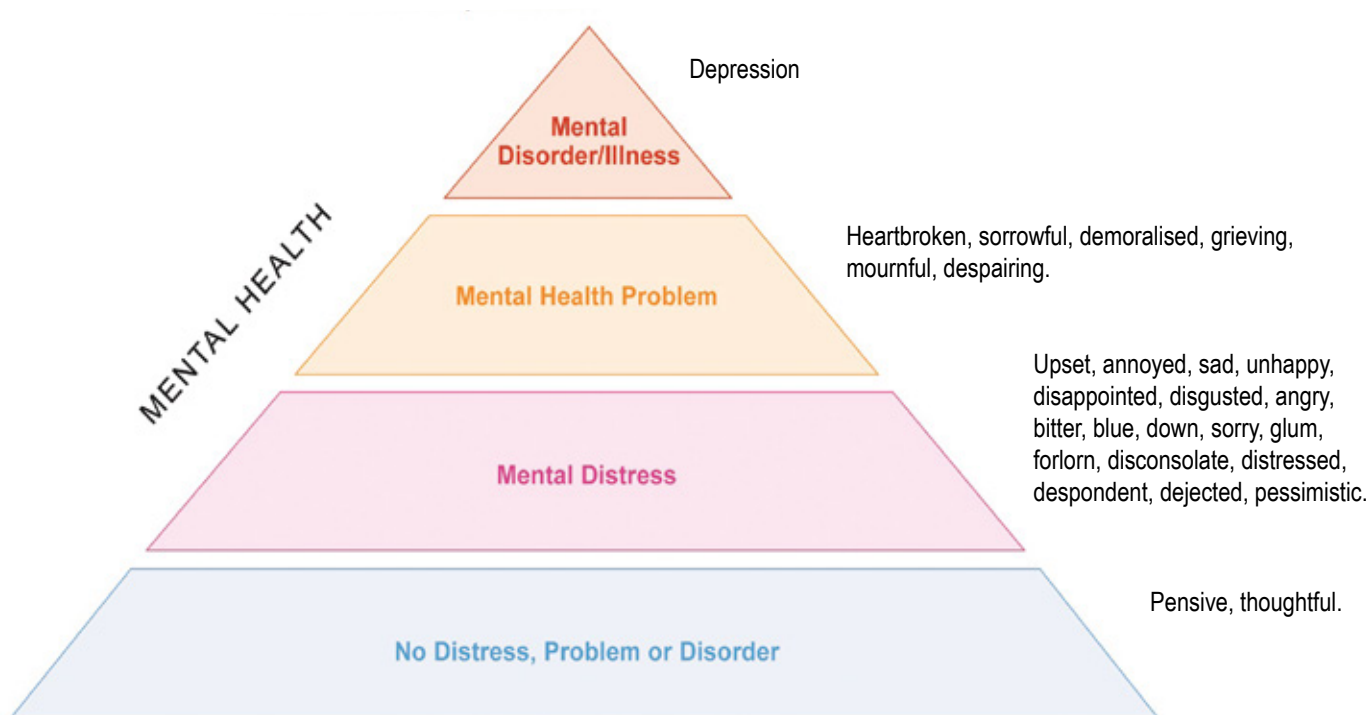
Mental Disorder? Yes, no, maybe.

Understanding how to differentiate a mental disorder from the usual “slings and arrows of outrageous fortune” is a core mental health literacy competency. This is discussed in the next section below and also repeated in the “Definitions” section of Module 2.

In the following diagram we can see the inter-relationship of different mental health states, discussed in more details below. They are unique states with different but related characteristics. On the right side of the figure are the various states and on the left side are the words that more properly describe each state. It is essential that our language be clear and convey what we intend it to mean. Using the word Depression when we mean upset is confusing and unhelpful in advancing understanding and communication.



THE INTER-RELATIONSHIP OF MENTAL HEALTH STATES: LANGUAGE MATTERS



Check out Dr. Kutcher's video blog, *The Inter-Relationship of Mental Health States: Language Matters* at: <https://www.youtube.com/watch?v=LsowyMnqCRs&t=1s>

Mental Health

There are many different definitions of mental health. Some are more clear and helpful than others. They all try to capture one important thing. That is, that a healthy brain is what gives us mental health. The brain is an important part of the body and the body and brain are linked. It is really not possible to consider them separately. We know that what is good for your body will be good for your brain as well, and vice-versa. Here is a definition that is clear and useful:

“Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with people and the ability to change and cope with adversity.”

– Surgeon General USA, (1999)

Basically, mental health means having the capacity to be able to successfully adapt to the challenges that life creates for people. These challenges are both positive and negative. In order to adapt to them our brains need to apply all of their capacities of: emotions, cognition/thinking, emotional responding and behaviours. Our brains learn how to apply these capacities over time and as we grow and develop we are able to take on more and more challenges and become successful in dealing with them. This is because we have faced these challenges and learned to deal with them.

Sometimes people forget that negative emotions are a part of good mental health. Crying, feeling sad, getting annoyed or angry, etc. are all normal responses to life challenges. So are negative thoughts such as:

“this is too hard for me” or “I am not a good person” or “people don’t like me”. So are negative behaviours, such as yelling at somebody or avoiding a situation that makes us feel stressed. It does not mean that we don’t have good mental health just because we feel stressed. Indeed, being able to identify stress and learn how to successfully overcome it in a way that solves the problem causing it is fundamental to having good mental health.

For example: feeling stressed about writing an examination could lead to a negative behaviour – such as going out to party with friends to drink and “forget” about the stress. Or it could lead to a neutral behaviour – such as going for a run or meditating to “release” the stress but not studying for the exam. But if that is your entire adaptive response you likely will not do well on your exam. The important coping strategy that your stress response should be eliciting from you here is to study or to get help from your instructor to assist you in understanding something that you may not know very well. If you add this coping strategy to your stress “releasing” activity you will be much more likely to succeed and that is a sign of good mental health. There will be more information on this important topic in Module 6.

Key Point:

It is important to understand that everyone has mental health just like everyone has physical health. And, just like a person can have good physical health and at the same time have a physical illness, people can have good mental health and a mental illness at the same time.

To understand mental health it is necessary to understand the three related components of mental health: mental distress, mental health problems and mental disorder. These are illustrated in the triangle diagram.

Mental Distress

Mental distress is the inner signal of anxiety or “stress” that a person has when something in their environment is demanding that they adapt to a challenge (for example: writing a test, giving a presentation in front of the class, asking a person to go out on a date, failing to make a school sports team, etc.). This is called a “stress signal” or “stress response”. A stress response has different components to it: emotions/feelings (such as worrying, unhappiness, feeling energised, annoyance), cognitions/thinking (negative thoughts such as “I am not good at anything”, “I wish I did not have to do this”, or positive thoughts such as “this is something I need to solve”, “it may be difficult but I can do this”, “I should ask my friend for their advice”), physical symptoms (such as stomach aches and headaches, the stomach “butterflies”) and behaviours (such as avoidance of the situation, engagement of the challenge, positive energy, withdrawal from others, yelling at someone or helping someone). As we can see, the stress response can have both negative and positive components! We need to make sure we don’t always focus on the negative ones.

Everybody experiences mental distress (often called “stress”) every day. It is a part of good mental health. It is a signal that tells us to try something new to solve the challenge we are facing. As the person who feels distress tries to develop solutions or strategies to solve the challenges (often called “stressors”) they figure out what works and what does not work well. Successfully dealing with the stressor (also called solving the problem) leads to learning what strategy worked and use of that strategy in similar situations in the future. The distress goes away once the person has successfully overcome the challenge. But the learning and skill sets remain and are ready to be used another time. This process is called adaptation or resilience building.

Young people experiencing everyday mental distress do not require counselling - they are not “sick” and they do not need treatment. They can learn how to manage the stress response and how to use the “stress signal” to develop new skills. They learn these skills by trial and error by obtaining advice from friends, parents, teachers, trusted adults and from other sources (such as the media). They can also use techniques that are part of general health management, such as: exercise, having enough sleep, being with friends and family, eating properly and staying away from drugs and alcohol. Sometimes what the young person tries does not work (for example: instead of studying for an exam they go out and party with their friends, instead of getting a good night’s sleep before an exam they try to stay up all night and study)



and as a result their distress may increase. But making wrong choices is part of learning how to make good choices. This is a normal part of growing up. Allowing young people to avoid everyday mental distress, or to focus only on teaching them how to modulate the stress response instead of how to use it to learn new skills, can have negative impacts on their development of skills that they need to learn in order to have successful adult lives.

Mental Health Problems

Mental health problems may arise when a person is faced with a much larger stressor than usual. These occur as an expected part of normal life and are not mental illnesses. For example: death of a loved one, moving to a new country, having a serious physical illness, etc. When faced with these large stressors, everyone experiences strong negative emotions (such as: sadness, grief, anger, demoralisation, etc.). These emotions are also accompanied by substantial difficulties in other domains such as: cognitive/ thinking (for example: “nothing will ever be the same”, “I don’t know if I can go on in my life”, etc.), physical (for example: sleep problems, loss of energy, numerous aches and pains), and behavioural (for example: social withdrawal, avoidance of usual activities, angry outbursts, etc.).

Sometimes the young person experiencing a mental health problem will exhibit noticeable difficulties in everyday functioning - at school and outside of school. In addition to the distress management skills and general health enhancing activities that are useful in decreasing mental distress, young people experiencing a mental health problem will often need additional support to help them through the difficult situation or assist them with problems in functioning (such as extra time for academic activities, time away from school to be with their families, etc.). In such cases, this support can come from a counsellor, a religious leader, or another person that has the skills needed to help effectively. Medical treatment (medication or psychotherapy) is usually not necessary. The presence of a supportive adult (such as a teacher, parent or neighbour) is a key component that can help young people deal with a mental health problem.

Mental Disorders

A mental disorder is very different from mental distress and from a mental health problem. It arises from a complex interplay between a person’s genetic makeup and the environment in which they live or have been exposed to at different times in their lives. A mental disorder (also called a mental illness) is a medical condition diagnosed by a psychiatrist or registered health professional that has had additional training in children’s mental health using internationally established diagnostic criteria. A person with a mental disorder is best helped by a trained health professional providing best evidence-based treatments. Mental disorders are the result of changes that arise in usual brain function as a result of a complex interplay between a person’s genes and environment. When a person has a mental disorder, their brain is not working as it should be.

A person with a mental disorder will experience significant, substantial and persistent challenges with emotions/feelings (for example: Depression, panic attacks, overwhelming anxiety, etc.), cognition/thinking (for example: delusions, disordered thoughts, hopelessness, suicidal thoughts, etc.), physical (for example: fatigue, lethargy, excessive movement, etc.), and behaviour (for example: school refusal and withdrawal from family and friends, suicide attempt, poor self-care, etc.). The presence of a mental disorder signifies that an individual needs best evidence-based interventions that may be of many different types (such as medications, psychotherapies, social interventions, etc.), provided by appropriately trained health care providers. While interventions that can help distress and mental health problems can also be used to help a person who has a mental illness, and general health enhancing activities are always useful, a young person with a mental disorder requires a degree of care above and beyond that usually provided for a mental health problem. Mental disorders require treatment using best evidence-based care by trained health professionals (such as: registered mental health practitioners, doctors, psychiatric nurses, psychologists, etc.).

A person can be in each of these states at the same time. For example, over the course of one day, a person can be laughing and having fun with their friends (no distress, problem or disorder), can experience distress (lost their house key), be experiencing a mental health problem (their uncle with whom they were close died earlier this week and they feel sad, lonely and cry), and have a mental disorder (such as Attention Deficit Hyperactivity Disorder).

What causes Mental Disorders?

A variety of different influences on the brain can lead to a mental disorder. Basically there are TWO major causes that can be independent or can interact: genetics (the effect of genes on brain development and brain function) and environment (the effect of things outside the brain on the brain – such as infection, malnutrition, severe trauma, etc.).

Both genetic and environmental factors exert their impact by affecting how brain cells and circuits function.

Diagnosis of Mental Disorders

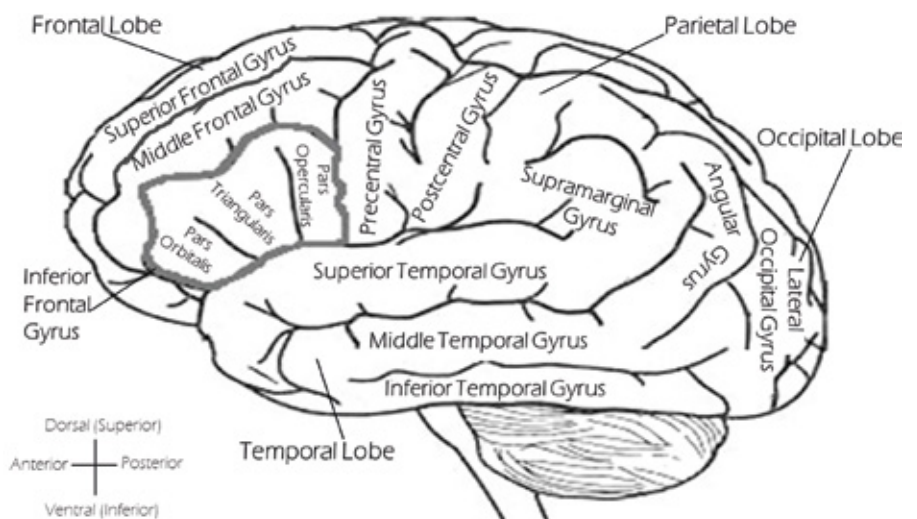
Diagnosis is one of the responsibilities of a trained and regulated health professional (e.g. psychologist, family GP, psychiatrist). It is not the professional competency of a teacher or other educator. If a teacher is concerned that a student may have a mental disorder, the teacher should make their concerns known to the person in the school most responsible for assessment of a student’s health state. Usually this is a counsellor, psychologist or a school nurse.

Remember to be aware of the language used. If a teacher says “Mary is Depressed” or “Michael has ADHD”, that can be considered to be assigning a diagnosis. Instead of this approach, carefully describe what you see. For example, “Mary looks sad, is crying much of the time and is not getting her school work done” or “Michael is getting up and down from his seat most of the time and is having difficulty sustaining his attention”.

If a student has a mental disorder, the teacher should become part of that person’s “circle of care team” and discharge their responsibilities consistent with their professional competencies, roles and responsibilities. Teachers are not therapists but they can be mentors, coaches and important supports.

The Human Brain: Where Mental Health Lives

- Planning
- Calculating
- Self-awareness
- Sequencing
- Judgement
- Comprehension
- Contemplation
- Reasoning
- Decoding symbols
- Focusing
- Paying attention
- Memory





Mental Disorders of Cognition & Perception: Psychotic Disorders

Psychotic disorders are a group of illnesses characterised by noticeable disturbances in the capacity to distinguish between what is real and what is not real. The person with psychosis exhibits major problems in thinking and behaviour. These include symptoms such as delusions and hallucinations. These result in many impairments that significantly interfere with the capacity to meet ordinary demands of life. Schizophrenia is an example of a psychotic disorder that affects about 1% of the population.

Who is at risk for developing Schizophrenia?

Schizophrenia (SCZ) often begins in adolescence and there is usually a genetic component. A family history of SCZ, a history of birth trauma and a history of fetal brain damage in utero increases the risk for SCZ. Significant marijuana use may bring on SCZ in young people who are at genetic risk for the illness.

What does Schizophrenia look like?

Delusions are fixed incorrect beliefs that are held with conviction and may involve misinterpretation of experiences. One common type of delusion is persecutory (also commonly called paranoid) in which the person thinks they are being harmed in some way by another person, force or entity (such as God, the police, spirits, etc.). Strongly held religious minority or cultural beliefs are not delusions.

Hallucinations are perceptions (such as hearing sounds or voices, smelling scents, etc.) that may occur in any sensory modality in the absence of an actual sensory stimulus. They can be normal during times of extreme stress or in sleep-like states. Occasionally they can occur spontaneously (such as a person hearing their name called out loud) but these do not cause problems with everyday life and are not persistent. In SCZ, hallucinations are experienced as real perceptions.

Thinking is disorganised in form and in content. For example, the pattern of speaking may not make sense to others or what is being said may not make sense or be an expression of delusional ideas.

Behaviour can be disturbed. This can range from behaviours that are mildly socially inappropriate to very disruptive and even threatening behaviours that may be responses to hallucinations or part of a delusion. Self-grooming and self-care may also be compromised. Rates of suicide in SCZ can approach 10% of those with the illness.

A young person with SCZ will also demonstrate a variety of cognitive problems ranging from difficulties with concentration to “higher order” difficulties such as with abstract reasoning and problem-solving. Most people with Schizophrenia will also exhibit what are called “negative symptoms” which include flattening of mood, decreased speech, and lack of motivation.

A person with SCZ may exhibit delusions, hallucinations and disordered thinking (also called “positive symptoms”) as well as negative symptoms (such as social withdrawal, lack of hygiene and motivation, etc.) at different times during the illness.

What are the criteria for the diagnosis of Schizophrenia?

1. Positive symptoms (delusions, hallucinations, disorganised thinking)
2. Negative symptoms (apathy, loss of pleasure, amotivation)
3. Behavioural disturbances (withdrawal, agitation, unexpected responses)
4. Significant dysfunction in one or more areas of daily life (social, family, interpersonal, schoolwork, etc.)
5. These features must last for at least 6 months during which time there must be at least one month of positive symptoms

What can I do if it is SCZ?

A young person with SCZ will require immediate access to effective treatment – usually in a specialty mental health program (first onset psychosis program). If a teacher suspects SCZ, the most appropriate student services provider should become involved. If concerns are shared, a referral to the most appropriate specialty mental health provider should be made and a discussion with the parents about the concerns should take place.

What do I need to watch out for?

Many young people with SCZ will demonstrate a slow and gradual onset of the illness – often over a period of 6-9 months or more. Early signs include; social withdrawal, odd behaviours, lack of attention to personal hygiene, excessive preoccupation with religious or philosophical constructs, etc. This phase of the illness is called the “prodrome”. Occasionally the young person suffering in the prodrome may exhibit unusual behaviours – often in response to a delusion or hallucinations. Sometimes it may be difficult to distinguish the early onset of SCZ (the prodrome) from other mental disorders – such as Depression or Social Anxiety Disorder. Young people suffering from the prodrome of SCZ may also begin abusing substances – particularly alcohol or marijuana and develop a Substance Use Disorder concurrently. Occasionally the young person may share bizarre ideas or may complain about being persecuted by others or may appear to be responding to internal voices. Rarely these delusions or hallucinations may be accompanied by unexpected violent acts.

Treatment for SCZ includes medications and a variety of psychological, social or vocational interventions depending on the person’s needs. Hospitalisation during acute psychotic episodes is often required.

Questions to consider asking:

Can you tell me what you are concerned about? Do you feel comfortable in school (your class)? Are you having any problems thinking? Are you hearing or seeing things that others may not be hearing or seeing?

Mental Disorders of Emotion and Feeling: Mood Disorders

There are two major types of mood disorders: unipolar mood disorders and bipolar mood disorders. Unipolar disorder can be a Major Depression or Dysthymic Disorder, whereas Bipolar Disorder occurs when a person experiences cycles of Depression and Mania.

Depression

Not to be confused with the word “depression” which is commonly used to describe emotional distress or sadness, Depression means Clinical Depression which is a mental disorder. Here, when we refer to the clinical condition we capitalise the letter “D”: Depression.



What are the different types of Depression?

There are two common kinds of clinical Depression: Major Depressive Disorder (MDD) and Dysthymic Disorder (DD). Both can significantly and negatively impact people's lives. They can lead to social, personal and family difficulties as well as poor vocational/educational performance and premature death due to suicide.

Additionally, patients with other illnesses such as heart disease and diabetes have an increased risk of early death if they are also diagnosed with Depression. This is thought to be due to the physiological effects that Depression has on your body as well as lifestyle effects such as poor self-care, increased smoking and alcohol consumption. Individuals with Depression usually require treatment from health professionals but in mild cases may experience substantial improvement with strong social supports and personal counselling.

What do MDD and DD look like?

MDD is usually a life-long disorder beginning in adolescence or early adulthood and is characterised by periods (lasting months to years) of Depressive episodes that are usually self-limiting in the early course of the illness. The episodes may be separated by periods (lasting months to years) of relative mood stability. Sometimes the Depressive episodes may be triggered by a negative event (such as the loss of a loved one, severe and persistent stress such as job loss or living in a conflict zone) but often the episodes occur spontaneously. Often there is a family history of Depression, Alcoholism, Anxiety Disorder or Bipolar Disorder. DD is a low-grade Depression that lasts for many years. It is less common than MDD.

What is a Depressive episode?

A Depressive episode is characterised by three symptom clusters: 1. mood 2. thinking (often called cognitive) and 3. physical (often called somatic). MDD may present differently in different cultures, particularly in the somatic problems that people identify. The symptoms of Depression must be distinguished from other negative emotional states such as grief. The symptoms of Depression:

- Must be severe enough to cause functional impairment (stop the person from doing what they would otherwise be doing, or decrease the quality of what they are doing)
- Must be continuously present everyday, most of the day for at least two weeks
- Cannot be due to a substance or medicine or medical illness and must be different from the person's usual state

These symptoms are:

Mood:

- Feeling "depressed", "sad", "unhappy" (or whatever the cultural equivalent of these descriptors are)
- Feeling a loss of pleasure or a marked disinterest in all or almost all activities
- Feelings of worthlessness, hopelessness or excessive and inappropriate guilt

Thinking:

- Diminished ability to think or concentrate or substantial indecisiveness
- Suicidal thoughts/plans or preoccupation with death and dying

Physical:

- Excessive fatigue or loss of energy (not just feeling tired)
- Significant sleep problems (difficulty falling asleep or sleeping excessively)
- Physical slowness or in some cases excessive restlessness
- Significant decrease in appetite that may lead to noticeable weight loss

Criteria:

Five of the above symptoms must be present everyday for most of the day during the same two week period; one of the five symptoms must be either depressed mood or loss of interest or pleasure. The symptoms must be substantial and different from the emotional, cognitive and physical challenges of everyday life.

What can I do if it is Depression?

If you are concerned that your student may have Depression, it is necessary to discuss this with the most appropriate health services provider in your school (e.g. counsellor, psychologist). The school-based health provider can provide counselling and support (including suggestions for self-help strategies). If the disorder is more intense or the person is suicidal, the school counsellor should immediately refer the person to the health professional best suited to treat the Depression. Once an intervention occurs and the young person is back at school it is important that the teacher be part of the ongoing treatment team and help develop and address learning needs. You may also need to continue to provide realistic emotional support such as encouragement of self-help activities (exercise, health eating, etc.)

Questions to ask:

Have you lost interest or pleasure in the things that you usually like to do? Have you felt sad, low, down or hopeless? Are you feeling that life is not worth living? If the student answers yes to either of these, further assessment of all of the symptoms should be conducted by the person in the school best trained to deal with this issue.

Things to look for:

People with Depression are at an increased risk for attempting suicide. Every person with Depression should be monitored for suicidal thoughts and plans. As a teacher you need to be aware that a Depressed student who begins to talk about suicide needs to be referred to their health provider immediately and your role is to bring this concern to the most appropriate, responsible professional in your school. To view an animated video on Depression visit: <https://www.youtube.com/watch?v=i8EPzcxAiVw&t=10s>

Treatment of Depression includes evidence-based psychotherapies such as Cognitive Behavioural Therapy (CBT) and medications.

Bipolar Disorder

- Illness is characterised by cycles (episodes) of Depression and Mania
- Depressions are similar to those that occur in MDD
- Mania includes mixed mood states of euphoria and irritability
- Cycles can be frequent (daily) or infrequent (many years apart)
- During Depressive or Manic episodes the person may become psychotic
- Suicide rates are high in people with Bipolar Disorder



In Bipolar Disorder how is 'Mania' different from feeling extremely happy?

- Mood is mostly elevated or irritable but can change rapidly
- Behavioural, physical and thinking problems are present
- Significant problems in daily life because of mood
- Mood may often not reflect the reality of the environment
- Is not caused by a life problem or life event

Bipolar Disorder – what to look for:

- History of at least one depressive episode and at least one manic episode
- Rapid mood changes including irritability and anger
- Self-destructive or self-harmful behaviours – including: spending sprees, violence towards others, sexual indiscretions, etc.
- Drug or alcohol overuse, misuse or abuse
- Psychotic symptoms including: hallucinations and delusions

A student with possible Bipolar Disorder requires immediate referral to a highly qualified mental health services provider.

Treatment of Bipolar Disorder will include medications as well as other evidence-based interventions. Hospitalisations for acute manic or Depressive states may be needed.

Mental Disorder of Emotional Response: The Anxiety Disorder

It is important to remember that anxiety is not the same thing as "stress". Many people confuse anxiety (which is a state of constant, severe and persistent hyperarousal not driven by danger) with the stress response (our brain/body signals that alert about an environmental challenge we need to address). When anxiety reaches such predominance that it interferes with a person's function and enjoyment of life - it is called Anxiety Disorder.

What is Generalised Anxiety Disorder (GAD)?

GAD is excessive anxiety and worry occurring for an extended period of time. This persistent, excessive anxiety and worry causes marked emotional distress, leads to many physical symptoms and causes functional impairment.

Who is at risk for developing GAD?

GAD often begins in childhood or adolescence and there is a genetic or familial component. Once GAD is present, the severity can fluctuate and exacerbations often occur during times of increased stress.

What does GAD look like?

Generalised Anxiety Disorder is characterised by excessive anxiety and worry about many different things. The state of hyperarousal is constant and the worries are out of proportion to the situation or event. This anxiety and worry must be persistent and noticeably greater than the usual socio-cultural norms. Young people with GAD often present with physical complaints such as headaches, fatigue, muscle aches and upset stomach. These symptoms tend to be chronic and young people may miss school or social activities because of these physical symptoms.

How do you differentiate GAD from normal worrying?

GAD symptoms can be broken into four categories:

- 1) Emotions – i.e. feeling fearful, worried, tense or on guard.
- 2) Body responses – many different body changes including increased heart rate, sweating and shakiness, shortness of breath, muscle tension and stomach upset.
- 3) Thoughts – with GAD, people are more likely to think about things related to real or potential sources of danger and may have difficulty concentrating on anything else. An example is thinking something bad is going to happen to a loved one.
- 4) Behaviours – people may engage in activities that can potentially eliminate the source of the danger. Examples include avoiding feared situations, people or places and self-medicating with drugs or alcohol. In GAD, the state of hyperarousal occurs when there is no real danger.

When does anxiety become a disorder?

- The state of hyperarousal is intense, persistent and excessive
- It leads to impairment or disability in work, school or social environments
- It leads to avoidance of daily activities in an attempt to lessen the anxiety

What are the criteria for the diagnosis of GAD?

1. Excessive anxiety and worry occurring for at least 6 months
2. Difficulty controlling the worry
3. The anxiety and worry are associated with 3 or more of the following: restlessness or feeling on edge, fatigued, difficulty concentrating, muscle tension or sleep disturbance
4. Anxiety and worry are not due to substance abuse, a medical condition or a mental disorder
5. The symptoms cause marked emotional distress and significant impairment in daily functioning

What can I do if it is GAD?

The first thing is to identify the problem for the young person and involve the school's student services provider who can elicit assistance from a person knowledgeable about the problem. Some people with GAD will experience improvements in their anxiety and functioning with supportive cognitive-based counselling. Others may require medication. Referral to an appropriate health professional for medical attention could be considered if the GAD is severe and if the functional impairment is extensive. For some, merely knowing that they have GAD and receiving supportive counselling from the school-based provider may be helpful enough.

Questions to ask?

Can you tell me about your worries? Do you or others see you as someone who worries much more than they should? Do you or others consider you to be someone who worries much more than most people do?



Do you have trouble “letting go of the worries”? Do you sometimes feel sick with worry? In what way? What things that you enjoy doing or would like to do are made less enjoyable or are avoided because of the worries?

What is Social Anxiety Disorder (SAD)?

Social Anxiety Disorder (sometimes called Social Phobia) is characterised by the presence of an intense fear of scrutiny by others, which can be perceived to result in embarrassment or humiliation.

What does SAD look like?

Young people with SAD fear doing something humiliating in front of others, or of offending others. They fear that others will judge everything they do in a negative way. They believe they may be considered to be flawed or worthless if any sign of poor performance is detected. They may cope by trying to do everything perfectly, limiting what they are doing in front of others and gradually withdrawing from contact with others. Young people with SAD may experience panic symptoms in social situations. As a result they tend to avoid social situations such as parties or school events. Some may have a difficult time attending class or may avoid going to school altogether. Although young people with SAD recognise that their fears are excessive and irrational, they are unable to control them and therefore avoid situations that trigger their anxiety. The presentation of SAD may vary across cultures, and although it may occur in children, it usually onsets in the adolescent years. It must not be confused with “shyness” and its intensity may wax and wane over time.

What are the criteria for diagnosis of SAD?

The following must be present for someone to have SAD:

- Marked and persistent fear of social or performance situations in which the person is exposed to unfamiliar people; fear of embarrassment or humiliation
- Exposure to the feared situation almost always provokes marked anxiety or panic
- The person recognises that the fear is excessive or inappropriate
- The avoidance or fear causes significant impairment in functioning and distress
- The feared social or performance situations are avoided or else endured with intense anxiety or distress
- The symptoms are not due to a substance, medicine or a general medical condition

What can I do if it is SAD?

The first step is the identification of the problem. Often, young people with SAD will have suffered for many years without knowing the reason for their difficulties. Sometimes just informing and educating them about the problem can be helpful. Treatment is not indicated unless the problem is causing significant functional impairment but counselling using cognitive behavioural techniques and exposure to the anxiety-provoking situation in the company of a counsellor may help the person better deal with their difficulties. If the disorder is severe, referral to an appropriate healthcare provider is needed, and the counsellor can provide ongoing support. A teacher may be able to assist in behaviour modification programs (such as getting used to a classroom situation). If you think a student may have SAD it is important not to draw attention publically to their difficulties but speak with them in private about what you notice – be supportive.

What do I need to watch out for?

Some young people with SAD will use excessive amounts of alcohol to help decrease their anxiety in social situations. In some cases, SAD can be a risk factor for the abuse of alcohol or other substances.

Questions to ask

Do situations that are new or associated with unfamiliar people cause you to feel anxious, distressed or panicky? When you are in unfamiliar social situations are you afraid of feeling embarrassed? What kinds of situations cause you to feel that way? Do those feelings of embarrassment, anxiety, distress or panic stop you from doing things you would otherwise do? What have you not been able to do as well as you would like to do because of those difficulties?

To view an animated video on SAD visit: <https://www.youtube.com/watch?v=kitHQWra7s>

What is Panic Disorder?

Panic Disorder is characterised by panic attacks which are rapidly onsetting, recurrent, unexpected episodes that include a number of frightening physical reactions, fear and irrational thoughts. The frequency and severity of panic attacks can vary greatly and can lead to agoraphobia (fear of being in places in which escape is difficult). Typically a panic attack comes on “out of the blue” and lasts less than 20 minutes.

Who is at risk for developing Panic Disorder?

The onset of Panic Disorder is commonly between the ages of 15-25. People who have first-degree relatives with Panic Disorder have a much higher risk of also developing Panic Disorder themselves.

What does Panic Disorder look like?

Young people with Panic Disorder experience recurrent, unexpected panic attacks and they greatly fear having another attack. They persistently worry about having another attack as well as the consequences of having a panic attack. Some may fear they are ‘losing their mind’ or feel they are going to die during a panic attack. Often they will change their behaviour to avoid places or situations that they fear might trigger a panic attack. In time, the person may come to avoid so many situations that they become bound to their home.

What are the components of a panic attack?

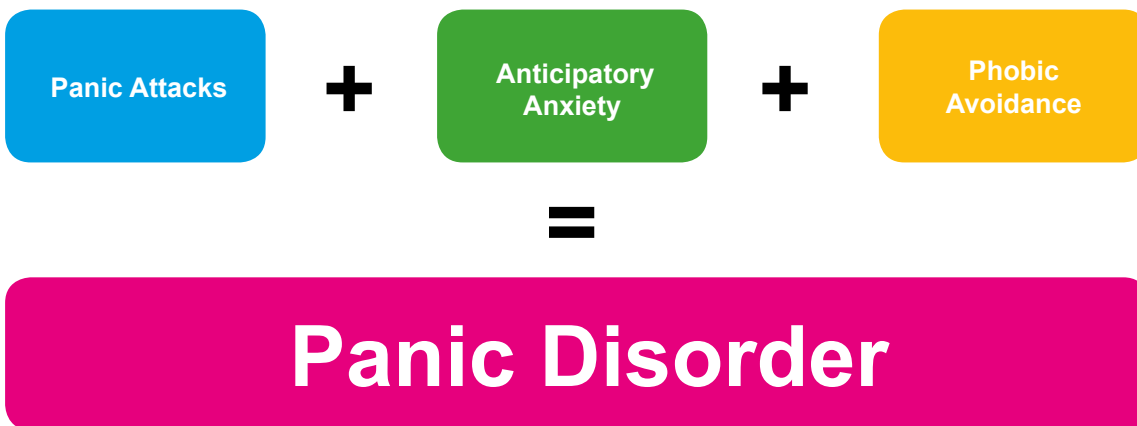
The person has four or more of the following symptoms which peak within 10 minutes:

- 1) Palpitations, pounding heart or accelerated heart rate
- 2) Sweating
- 3) Trembling or shaking
- 4) Sensations of shortness of breath or smothering
- 5) Feeling of choking
- 6) Chest pain or discomfort
- 7) Nausea or abdominal pain
- 8) Feeling dizzy, unsteady, lightheaded or faint
- 9) Feeling of unreality or being detached from oneself



- 10) Fear of losing control or going crazy
- 11) Fear of dying
- 12) Numbness or tingling in the body
- 13) Chills or hot flashes

The Panic Disorder Triad



What are the criteria for Panic Disorder?

Assessing Panic Disorder involves evaluating five areas:

- 1) Panic attacks
- 2) Anticipatory anxiety
- 3) Panic related phobic avoidance
- 4) Overall illness severity
- 5) Psychosocial disability

For a diagnosis of Panic Disorder, a patient must have:

- 1) Recurrent unexpected panic attacks
- 2) One or more of the attacks has been followed by ≥ 1 month of:
 - Persistent concern of having additional attacks
 - Worry about the implications of the attack or its consequences
 - A significant change in behaviour as a result of the attacks
- 3) Agoraphobia
- 4) Panic attacks that are not due to substance abuse, medications or a general medical condition
- 5) Panic attacks that are not better accounted for by another mental disorder

What can I do if it is a Panic Attack?

The first thing is to identify the panic attack and provide a calm and supportive environment until the attack passes. Education about panic attacks and Panic Disorder is often very helpful and should ideally be provided by a professional with good knowledge in this area.

Counselling or psychotherapy using cognitive behavioural methods may be of help and medications can be used as well. The teacher's role in helping a young person suffering from a panic disorder can also involve assisting them in dealing with their anxieties about having another attack and also helping them with strategies to combat avoidance of social situations. Therefore it is a good idea for a teacher to be part of the treatment planning and treatment monitoring for a young person with Panic Disorder.

Questions to ask?

Can you describe in your own words what happens when you have one of these episodes (some people will refer to them as “spells”)? How many of these episodes have you had in the last week? In the last month? What do these episodes stop you from doing that you would otherwise usually do? What do you do when these episodes occur?

Things to look for:

Young people with panic disorder are at higher risk for developing Depression. If the person appears sad or hopeless and has suicidal thoughts, a diagnosis of Depression must also be suspected. Some young people with Panic Disorder may also develop substance abuse problems (particularly alcohol) and counselling around these issues is very important. To view an animated video on Panic Disorder visit: https://www.youtube.com/watch?v=R3S_XYaEPUs

Treatments for Anxiety Disorders include evidence-based psychotherapies and in some cases, medications. Accommodations in school should be applied with the goal of improving function not avoidance.

Young people with Anxiety Disorders will often use avoidance as a preferred coping strategy. Avoidance makes the anxiety worse and limits a person's ability to deal with it. Indeed, the basic therapeutic intervention for Anxiety Disorders is to help the young person learn to not avoid. In the school setting, be sure that avoidance is not enabled. If accommodations are needed they should be limited in duration and be focused on helping the student regain function. Accommodations for an Anxiety Disorder should be part of a treatment plan designed to restore functioning so that accommodations are no longer needed. They are a means to an end, not an end in themselves.

Examination anxiety does not exist. There is no such thing as “examination anxiety”. There is the stress response to taking an examination. It is normal. It is expected. It has a purpose – to prepare your pupils to take the examination (or job interview or any other life task or challenge). Calling this normal stress response “examination anxiety” creates an expectation of disorder, and creates an unnecessary pathology. In some cases this label is used to support avoidance.

Most pupils experience mild to moderate degrees of examination induced stress response. They need to be assured this is normal and has a purpose – to drive behaviours that will help achieve success. The intensity of the response can be decreased using the box-breathing technique taught in Module 6.



Some pupils with a pre-existing Anxiety Disorder will experience an enhanced stress response to the examination stressor. Some pupils who have learned to fear or avoid the examination stressor may also experience an enhanced stress response. Avoidance of the stressor for these pupils is not helpful – it actually leads to a lack of resilience and even learned helplessness. For pupils with an exaggerated stress response, desensitisation techniques that can be taught by a school counsellor and reinforced by the teacher should be applied from the beginning of the school year. In addition study skill development, cognitive reframing of the stress response from fear to preparation/excitement and the practice of stress reduction techniques should be employed. Accommodation should be used as a step towards full participation. It is a means to an end, not an end in itself.

Other Mental Disorders with Hyper Arousal Symptom: OCD & PTSD

What is Obsessive Compulsive Disorder?

Obsessive Compulsive Disorder (OCD) is characterised by obsessions and/or compulsions. Obsessions are persistent, intrusive, unwanted thoughts, images or impulses that the person recognises as irrational, senseless, intrusive or inappropriate but is unable to control. Compulsions are repetitive behaviours which the person performs in order to reduce anxiety associated with an obsession. Examples of these are counting, touching, washing and checking. Both can be of such intensity that they cause a great deal of distress and significantly interfere with the person's daily functioning. Obsessions are different from psychotic thoughts because the person knows that they are their own thoughts (not put inside their head by some external force) and the person does not want to have the thoughts.

Compulsions are different from psychotic behaviours because the person knows why they are doing the activity and can usually say why they are doing them.

Who is at risk for developing OCD?

OCD often begins in adolescence or early adulthood, although it can start in childhood. It can affect anybody. First-degree relatives of people with OCD are more likely to develop OCD.

What does OCD look like?

OCD should not be confused with superstitions or those repetitive checking behaviours that are common in everyday life. They are also not simply excessive worries about real life issues. A person with OCD will have significant symptoms of either obsessions or compulsions or both. These symptoms will be severe enough to cause marked distress, are time consuming (take up more than one hour per day) and significantly interfere with a person's normal activities (work, school, social, family, etc.).

To view an animated video on OCD visit: <https://www.youtube.com/watch?v=ua9zr16jC1M>

Obsessions:

- Recurrent and persistent thoughts, impulses or images that are experienced as intrusive and not appropriate and cause significant distress or anxiety

- These symptoms cannot be simply excessive worries about everyday life
- The person with these symptoms tries to suppress or ignore them. The person may try to neutralise, decrease or suppress the thoughts with some other thought or action.
- The person knows that the thoughts are coming from their own mind

Compulsions:

- Repetitive behaviours (such as checking, washing, ordering) or mental acts (such as counting, praying, repeating words silently) that the person feels driven to perform in response to an obsession or according to rigid rules
- These behaviours or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation BUT are not realistically connected to the obsessions they are meant to neutralise

What can I do if it is OCD?

If you are concerned your student has OCD, you should support the student to access the school guidance or health professional who can then refer the student to the professional best suited to provide treatment and you can continue to provide support to the student as part of their “circle of care”. Usually young people will be treated with Cognitive Behavioural Therapy (CBT) and a Selective Serotonin Reuptake Inhibitor (SSRI) medication. It is important to know if any academic modifications need to be made to enhance learning opportunities for young people with OCD, so including the teacher in treatment planning and treatment monitoring is usually necessary.

Questions to ask:

Are you having thoughts that are coming into your mind that you do not want to be there? Do those thoughts cause you to feel uncomfortable or anxious or upset? Do you think that those thoughts are true? How are you trying to deal with or stop the thoughts from coming? What do the thoughts stop you from doing that you would otherwise be doing? Please describe the things that you are doing that are causing distress to you or other people. Can you tell me why you are doing those things? What do you think will happen if you do not do those things? What do those things that you are doing stop you from doing that you would otherwise be doing?

Things to look for:

There are two main things to watch out for. The first is the possibility that the symptoms could be part of a psychosis. Therefore it is very important to rule out a psychotic disorder. The second thing to watch for is the effect OCD has on the young person’s classmates. Sometimes pupils with severe OCD will try to involve their classmates (or their teachers) in their compulsions. If this happens then it can cause significant problems at school. Educating yourself about OCD and the importance of not participating in the OCD ritual is important.



What is Post Traumatic Stress Disorder?

Post Traumatic Stress Disorder (PTSD) develops after a significant trauma occurs that was either experienced or witnessed by the young person. It involves the development of psychological reactions related to the experience such as recurrent, intrusive and distressing recollections of the event. These may be in the form of nightmares, flashbacks and/or hallucinations. Recent widening of diagnostic criteria have included repeated or extreme indirect exposure in the performance of professional duties. This is not the same as watching tragic events on the television. It is essential not to confuse normal negative emotions with PTSD. Feeling upset about a stressful event is not PTSD. Feeling upset when remembering a stressful time or event is not PTSD. The word trauma and the phrase “traumatic experience” should be reserved for severe, substantive and significant (often life-threatening) events. They should not be used to describe stress-provoking and difficult, unusual or common challenges of life.

Who is at risk for developing PTSD?

Not all people who have experienced a traumatic event will develop PTSD. Most will not. Risk factors include personal or family history of Depression, severity and persistence of the trauma.

What does PTSD look like?

The symptoms of PTSD develop around 6-8 weeks following the traumatic event and are organised into different categories:

- **Intrusion Symptoms** – recurrent, intrusive, distressing recollections or memories of the event in the form of memories, dreams, or flashbacks in which the individual perceives themselves to be re-living the event as though it was actually happening again in the present.
- **Avoidance Symptoms** – avoidance of things – people, places, topics of conversation, food, drink, weather conditions, clothing, activities, situations, thoughts, feelings – that are associated with or are reminders of the traumatic event. In addition the person may experience a general sadness, numbing of emotions, a loss of interest in previously enjoyed activities, detachment from family and friends, and a sense of hopelessness about the future.
- **Hyper Arousal Symptoms** – sleep problems (difficulties falling asleep or staying asleep), irritability, aggression, angry outbursts, hypervigilance, self-destructive behaviour, exaggerated startle response, and difficulty concentrating.
- **Negative Cognitive/Emotional Symptoms** – Unable to recall key aspects, persistent and disturbed negative feelings, self-blaming, guilt, shame, detachment, decreased interest in activities.

What are the criteria for the diagnosis of PTSD?

1. The person has been exposed to a traumatic event in which both of the following were present:
 - The person felt their life was in danger or witnessed someone else’s life put in danger
 - The person experienced extreme fear, helplessness or horror
2. The traumatic event is re-experienced, including one or more of:
 - Recurrent intrusive memories, dreams or nightmares reliving the event which causes psychological distress.

3. Avoidance of things associated with the event including 3 or more of:
 - Avoiding thoughts, feelings or conversations, avoiding activities, places or people, inability to recall aspects of the trauma, decreased interest or participation in activities, feeling detached or estranged from others, restricted range of affect, sense of foreshortened future.
4. Persistent symptoms of increased arousal including 2 or more of:
 - Difficulty falling or staying asleep, irritability, difficulty concentrating, hypervigilance, exaggerated startle response time, risky or disruptive behaviour.
5. Duration of symptoms greater than 1 month:
 - Severity of symptoms causes marked distress and impairment in daily functioning.

The symptoms have to be present for at least one month and must cause functional impairment (at home, at school, at work, etc.)

For some people, these symptoms may not appear until a number of months after the experienced event.

How does PTSD differ from Acute Stress Disorder or normal grieving?

It is normal to remember traumatic events and to feel distress or discomfort when doing so. This is not PTSD.

PTSD must be distinguished from normal responses (such as grief, acute stress response, etc.) to such situations and from Acute Stress Disorder (ASD). ASD has similar symptoms to PTSD but ends or is diminished greatly sometimes without formal treatment within about four weeks of the traumatic event. Psychotherapies or SSRI medication may be used to treat ASD. Duration and severity of PTSD symptoms may vary over time with recovery occurring within half a year (or less) in about half of cases.

What can I do if it is PTSD?

The first thing is to identify the young person with PTSD and help them to access specialist support. The role of the school is not to treat but to suggest treatment. It is important not to confuse PTSD with normal responses to traumatic events (often called an acute stress response) or with ASD. Do not create pathology where it does not exist. For people with PTSD, supportive counselling using cognitive therapy methods may be of help. If the disorder is causing significant distress and impairment, referral to a specialist health care provider is indicated, as medication or specific types of psychotherapeutic treatments may be needed.

What questions can I ask?

Are you bothered by memories or thoughts of a very upsetting event that has happened to you? What kinds of things are you experiencing? How is this affecting your life?

Things to look for:

Some people who are exposed to significantly traumatic events may have exacerbations of pre-existing mental disorders such as Depression or Psychosis. Identification and proper effective interventions for these people in the post traumatic situation is important. Substance abuse, especially involving alcohol is common in people who have PTSD. Therefore it is important to screen for this problem in people with PTSD and to treat appropriately.

Treatment for PTSD usually requires both an evidence-based psychotherapy plus medication.



Mental Disorders of Physical: Eating Disorders

What is an Eating Disorder?

There are two main types of Eating Disorders: Anorexia Nervosa (AN) and Bulimia Nervosa (BN). While there may be some overlapping symptoms between the two, they are likely to have different causes and the treatments for them differ.

Who is at risk for developing an Eating Disorder?

Eating Disorders usually begin in adolescence and may continue into adulthood. Girls are much more commonly affected than boys, but anyone may develop an Eating Disorder

What does Anorexia Nervosa look like?

Anorexia Nervosa is characterised by excessive preoccupation with body weight control, a disturbed body image, an intense fear of gaining weight and a refusal to maintain a minimally normal weight. Post-pubertal girls also experience a loss of menstrual periods. There are two subtypes of AN – a restricting subtype (in which the young person does not regularly binge, abuse laxatives or engage in self-induced vomiting) and a binge-eating/purging subtype (in which the young person regularly binges and abuses laxatives or self-induces vomiting).

What does Bulimia Nervosa look like?

Bulimia Nervosa is characterised by regular and recurrent binge-eating (large amounts of food over a short time accompanied by a lack of control over the eating during the episode) and by frequent inappropriate behaviours designed to prevent weight gain (including but not limited to: self-induced vomiting, use of laxatives, enemas, and/or excessive exercise).

How do you differentiate an eating disorder from normal teenage eating?

Eating patterns in young people can be very erratic. Food fads are common as are periods of dieting and food restriction (often in response to concerns about weight). Adolescence is also a period in which some young people experiment with food types and eating patterns that may differ substantially from those common to their families or communities. These are not eating disorders.

What are the criteria for the diagnosis of Anorexia Nervosa (AN)?

- 1) Refusal to maintain body weight at or above a minimally normal weight for age and height resulting in a body weight less than 85% of that expected.
- 2) Intense fear of gaining weight or becoming fat while underweight.
- 3) Substantial disturbances in body image (considers self to be fat even though is underweight) or denial of seriousness of current low body weight.
- 4) Loss of menstrual periods in post-pubertal girls.

What can I do if it is AN?

Young people with AN do not complain about having AN and most deny that they have a problem with being underweight. Usually a friend, teacher or family member will notice the severe weight loss. An educator who is concerned that a student may have AN should gently and supportively discuss the issue with the young person and if after that discussion it seems as if there is a possibility of AN, the young person should be referred to the appropriate support person or health provider in the school for further assessment and intervention. Suggestions that the young person eat more or negative comments on their weight are counterproductive.

Treatments for AN are based on maintenance of an appropriate body weight and psychological interventions. Medications are not effective in AN. Treatment for AN usually requires a sub-specialty mental health eating disorders service.

Things to look for:

Some people with AN may go on to develop Depression or other severe medical problems. Some young people may begin to avoid class or other school activities. Frequently, young people with AN will avoid eating at times all other young people are eating (such as lunch time in the school cafeteria).

What are the criteria for the diagnosis of BN?

- 1) Recurrent episodes of binge-eating where both of the following are present: a) eating large amounts of food in a short period of time; b) feeling that eating is out of control.
- 2) Recurrent inappropriate behaviours in order to control weight (such as: self-induced vomiting; misuse of laxatives, diuretics, enemas or other medications, fasting or excessive exercise).
- 3) The above must occur on average at least twice a week for a period of 3 months.
- 4) Self-perspective is overly influenced by body shape and weight.
- 5) The above does not occur exclusively during BN.

There are two subtypes of BN – the purging type (characterised by self-induced vomiting, or misuse of laxative, diuretics, enemas, etc.); the non-purging type (no use of the above).

What can I do if it is BN?

Young people with BN do not complain about having BN and most deny that they have a problem with eating. BN is often hidden. Classroom discussions about BN and other eating problems should be undertaken with the sensitivity that there may be a young person with unknown or unrecognised BN in the group.

Treatment for BN includes both psychological therapies and medications.

Questions to ask:

How do you feel about yourself? Has anyone asked you if you were having problems with your eating? Do you sometimes feel that your eating may be out of control?



Mental Disorders of Behaviour: Substance Related Disorders, ADHD and Conduct Disorder

Substance Use Disorder

There is a spectrum of harm that can develop from using various substances. Along this spectrum of harm is abuse and dependence.

Substance Related Disorders

Substance use and substance misuse occur commonly in young people and are not the same as Substance Use Disorders or Substance Induced Disorders. However, the onset of the latter most commonly occurs during the teen years. Currently, caffeine, alcohol and tobacco are the most commonly used substances, and cannabis is the most commonly used illegal drug. Clinical interventions to help young people who are misusing substances are often provided based on the realisation that some types of substance misuse may raise the probability of substance related harm, even if the young person does not go on to develop a Substance Use Disorder. Indeed, most people who misuse substances in their youth do not go on to develop a Substance Use Disorder.

Substance Use Disorders (SUDs) are characterised by excessive and continued use of substances in spite of numerous negative consequences (physical, social, academic/vocational, interpersonal and legal). People with SUDs crave the substance and exhibit persistent drug seeking behaviours which can include various anti-social components, such as theft. Young people who meet diagnostic criteria for a SUD require intensive treatment that may include short-term residential care. Treatment relapse is common. Substance Induced Disorder describes the impact of a substance on a person at a particular point in time. For example, this includes intoxication or withdrawal.

Substance Induced Disorder (SID) can occur without the presence of Substance Use Disorder. For example, a young person can be intoxicated from excessive use of alcohol and behave inappropriately or dangerously (driving a car) or be admitted for emergency medical care due to an inability to function or as a result of a neurological event (such as a seizure). During this time, the person would be considered to exhibit a Substance Induced Disorder. Many young people, especially if they are involved in binge drinking of alcohol, can meet diagnostic criteria for SID if excessive amounts of alcohol are ingested over a short period of time. This would be called Alcohol Induced Disorder.

Some SIDs can, in the short term, be difficult to distinguish from certain types of mental disorders, such as psychosis or mood disorders. This is because the substance can elicit delusions and hallucinations or severe Depressions or extreme excitement and agitation. In such cases, admission to hospital is often indicated - both to treat the SID and also to differentiate symptoms related to an SID from those of a psychosis or mood disorder.

With Substance Use Disorder, the person demonstrates a longstanding pattern of negative behaviours as described above related to the persistent seeking out of and use of a particular substance. For example, a person with Alcohol Use Disorder could be intoxicated for hours in a day, may steal to obtain funds to purchase alcohol, may neglect their personal hygiene when drinking, may run afoul of the law or act inappropriately at school, etc.

Individuals with SUDs may frequently also demonstrate SID at numerous points over time, while many people who demonstrate SID at infrequent time points may not meet diagnostic criteria for SUD. Sometimes medications are used depending on the substance and the situation. This pattern of behaviour would occur frequently over time and would be associated with significant functional impairment (for example: failing at school; legal charges, traffic accidents while drinking, etc.).

There are many types of SUDs. A SUD can occur with substances that are legal (for example: tobacco or alcohol) or illegal. These include but are not limited to: Alcohol Use Disorder, Cannabis Use Disorder, Opioids Use Disorder, etc. Not infrequently, the type of SUD can change over time or a person can meet criteria for more than one SUD concurrently.

Treatments are a combination of psychological and social (often peer-supported) interventions.

What is Attention Deficit Hyperactivity Disorder?

Attention Deficit Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder characterised by a persistent pattern of hyperactivity, impulsivity and substantial difficulties with sustained attention that is outside the population norm and is associated with substantial functional impairments at school, home and with peers. This disorder begins early in life and continues into adolescence and for some people, into adulthood.

Who is at risk for ADHD?

ADHD has a genetic component and is more common in boys. Girls who have ADHD often do not have similar problems with hyperactivity although they have problems with sustaining attention and impulsivity. Young people who have learning disabilities and young people with Tourette's Syndrome have higher rates of ADHD. Young people with Conduct Disorder may have ADHD which has not been recognised or treated and which may contribute to their social and legal difficulties. About 30% of young people with ADHD have a learning disability.

What does ADHD look like?

Not all pupils who demonstrate challenges with sustained attention have ADHD. Problems with sustaining attention may result in substantial difficulties in on-task behaviours. Young people with ADHD frequently make multiple careless errors, do not complete their academic or home-based tasks and may start but not complete numerous activities. They are easily distracted by stimuli in their environment (such as noise) and often will begin to avoid tasks that require significant attention (such as homework). Young people with ADHD will often rush into things such as games or other activities without taking the time to learn the rules or determine what they should do.

Hyperactivity is often manifested by difficulties staying still in one place – such as sitting at a desk or in a group. Younger children may run around the room (or climb on furniture, etc.) instead of focusing on group activities. Most young people with ADHD have trouble sitting still and are very active – often they will fidget, talk excessively, make noises during quiet activity and generally seem 'wound up' or 'driven'.

Impulsivity is often shown as impatience or low frustration tolerance. Young people with ADHD will often interrupt others, fail to listen to instructions, rush into novel situations without thinking about the consequences, etc. This type of behaviour may lead to accidents. Many young people with ADHD also do not seem to be able to learn quickly from negative experiences – it is as if the impulsivity overrides learning about dangers. These difficulties can be less pronounced in activities that require a great deal of physical



participation and are constantly engaging. Sometimes young people with ADHD seem less distracted when they are playing games that they like – especially games that do not require sustained attention (such as video games). Symptoms are more likely to be noticed when the young person is in a group setting in which sustained and quiet attention is needed or when they are working in an environment in which there are many distractions.

What are the criteria for diagnosis of ADHD?

There must be a number of symptoms from each of the following categories: inattention, hyperactivity, impulsivity, plus a duration of at least six months to a degree that the person demonstrates maladaptive behaviours and trouble functioning that is inconsistent with their level of development. These must be significantly greater than other pupils of similar age.

Inattention (at least six of the following):

- 1) Failure to give close attention or many careless errors in work requiring sustained attention (such as school work)
- 2) Difficulty sustaining attention in tasks or play
- 3) Does not seem to listen when spoken to directly
- 4) Does not follow through on instructions
- 5) Has difficulty organising tasks and activities
- 6) Avoids tasks that require sustained attention (such as homework)
- 7) Loses things needed for tasks and activities
- 8) Easily distracted by the environment
- 9) Forgetful in daily activities

Hyperactivity

- 1) Blurts out comments or answers to questions before they should
- 2) Has difficulty waiting their turn
- 3) Often interrupts or intrudes on others
- 4) Often “acts” without thinking
- 5) Fidgets or squirms while seated
- 6) Leaves seat in classroom when they are supposed to be seated
- 7) Runs about or climbs excessively when not appropriate
- 8) Has difficulty in solitary play or quiet activities
- 9) Is usually on the go, as if motor driven
- 10) Often talks excessively
- 11) Impulsivity

What can I do if it is ADHD?

ADHD can be treated with a combination of medications and other assistance – such as social skills training and Cognitive Behavioural Therapy. The most effective treatment for symptoms is medication. Because learning difficulties are common, young people with ADHD should undergo educational testing to determine if a learning disability is present. Sometimes young people with ADHD will benefit from modifications to their learning environments such as having quieter places in which to work or having homework done in small amounts over longer periods of time. Some young people with ADHD will develop conduct disturbances or substance misuse. Many will become demoralised because of constant reminders from teachers, parents and others about their ‘bad behaviour’.

Remember that these young people are not bad - they simply have difficulties with sustained attention. Try not to decrease their self-esteem by focusing only on what they have difficulty doing - focus on their strengths as well.

Questions to ask?

Are you having difficulties focusing on your schoolwork? Is it hard for you to finish your work if there are noises or distractions? Do your parents or teachers seem to be nagging you all the time to do your work and sit still?

What is Conduct Disorder?

Severe, persistent and challenging behaviours that threaten the safety, security or physical integrity of others are the phenomena that comprise Conduct Disorder (CD). Young people with CD act with aggression and even violence towards others, either in response to a challenge or without provocation. They threaten (verbally and physically) and intimidate others and can cause physical harm to others, including assault with a weapon. They commonly engage in property damage or theft and frequently violate norms of social behaviour such as running away from home, lying, school truancy and bullying of others. Young people with CD have higher rates of substance misuse, difficulties with the law (for example: arrests and convictions), traffic accidents, school non-completion and poorer economic/vocational outcomes. They may be involved in various illegal activities including crimes against people and property. A sub-group of those with CD may later in life meet diagnostic criteria for Anti-Social Personality Disorder and rates of Attention Deficit Hyperactivity Disorder and Substance Use Disorder are higher in young people with CD.

Behaviours Related to Mental Disorders: Suicide and Self-Harm

What is suicide?

Suicide is the act of ending one's life. Suicide is the outcome of a behaviour, it is not a mental disorder. However one of the most important causes of suicide is mental illness – most often Depression, Bipolar Disorder (Manic Depression), Schizophrenia, and Substance Use Disorder.

Suicide is found in every culture and is the result of complex social, cultural, religious and socio-economic factors in addition to mental disorders. The reasons for suicide may vary from region to region. Because of this, it is important to know what the most common reasons for suicide are in the region in which you are working. This may be difficult to determine accurately because of the “taboos” and stigma around suicide.

The preferred methods of completing suicide may vary from location to location – ranging from firearms to fertiliser poisoning to self-burning to overdosing on pills. Therefore, it is also important to know the most common methods of suicide in the region in which you are working. For more information, check out this link: <http://teenmentalhealth.org/learn/suicide/>.

How are suicide and self-harm different?

Self-harm is a behaviour initiated for many different reasons. These include but are not limited to: onset of a mental illness, experience of overwhelming stress (such as ongoing sexual abuse), pressure to be part of a subculture, and/or different problem-solving skills. Teachers should not try to “understand” or “control” young people who self-harm. Referral to a specialised mental health provider is needed. Self-harm behaviours are not attempts to die. Suicide attempts are distinguished from self-harm behaviours by a person's wish to die. Educators may be faced with situations in which they encounter pupils self-harming.



Do not panic. Calmly bring the student to the most appropriate “in school” support. When discussing self-harm, it is useful to explain the behaviour as an attempt to solve a problem and to note that better solutions exist. Encourage the student to work towards using those. Do not get involved in discussions about self-harm.

Suicidal behaviour has three components: ideation, intent, and plans.

1. Suicidal ideation includes ideas about death or dying, wishing that they were dead, or ideas about committing suicide. These ideas are not persistent for some young people but for some they can become so. These ideas can be fairly common in people with mental disorders or in people who are in difficult life circumstances. Most people with suicidal ideation do not go on to attempt suicide but the suicidal ideation is a risk factor for suicide.
2. The second component is suicidal intent. With suicidal intent, the idea of suicide is better formed and more consistently held than in suicidal ideation. A person with suicidal intent may think about suicide most of the time, imagining what life would be like for friends and family without them, etc.
3. The third component is the suicide plan. This is a clear plan of how the act of suicide will occur. Vague plans (such as “someday I will jump off a bridge”) are considered as part of intent. In a suicide plan the means of suicide will be identified and obtained (such a gun, poison, etc.) and the place and time will be chosen. The presence of a suicide plan constitutes a psychiatric emergency.

Pupils who exhibit suicide ideation or have intent may benefit from supportive or cognitive based counselling. The presence of a suicide plan should lead to placement of the person in a situation in which they can be safe and secure. That situation should be therapeutic and not punitive, and should be accompanied by supportive and cognitive counselling. Any mental disorder should be treated. If a suicide has happened, the family or loved ones may benefit from non-judgmental supportive bereavement counselling.

Do not keep suicide concerns or self-harm behaviours confidential.

If a teacher is faced with a student who is talking about or writing about suicide then it is important to include the most appropriate student services provider to assess the situation.

Supportively accompany them to the most responsible student health provider in the school so that an assessment of risk can be conducted. Generally it is better to err on the side of caution and take the young person to a location in which they can be safe. Schools should have policies about how to deal with a suicidal young person – know your school’s policy. If there is no policy, bring this issue to the attention of the Head teacher.

If a young person dies by suicide, there can be negative repercussions amongst peers, classmates and teachers. It is important not to force pupils or others into reliving or analysing the event. Traditional Critical Incident Stress Debriefing interventions have not been shown to be helpful and may even cause harm. Bringing grief counsellors into a school is not usually helpful. A supportive space for those pupils who wish to use it should be provided after school hours and a teacher or guidance counsellor known to the pupils should ideally be available for those who wish to talk. Each community will have its own traditions for dealing with this kind of event and it is not necessary to create highly effective responses to a suicide in the school setting.

Self-harm can become a preferred (but unhelpful) approach to problem-solving. Certain mental illnesses (such as Bipolar Disorder) may lead to self-harm because of unstable mood. Sometimes self-harm behaviours can become part of a group identity. Contagion effects can occur in both self-harm and suicide attempts.

What are risk factors for suicide?

The following are the most common (and strongest) risk factors for suicide in young people. Remember that a risk factor does not cause an event to happen. Rather, it is something that increases the probability of an event.

- Depression or other mental disorder
- Previous suicide attempt
- Family history of suicide
- Excessive alcohol or drug use

Suicide risk is higher in people with mental disorders, in particular those with: Depression, Bipolar Disorder (Manic Depression), Schizophrenia, and Substance Use Disorder. If a young person talks to you about suicide, take them seriously and take them to the person in the school best able to help. Do not keep suicide or self-harm confidential. It is not helpful to engage in persistent public discourse about suicide or self-harm. Pupils need to know that the presence of suicidal thoughts is a signal that they need help and that they should reach out to a responsible adult for assistance.

What can I do if it is Suicide?

The first thing is to identify the presence of suicide ideation, intent and plans. Young people who have thoughts of suicide should be advised to approach a trusted adult for assistance. Pupils who self-harm can be counselled to seek alternative and better methods to solve problems.

Questions to ask?

It seems as if things have been difficult for you - can you share how you are feeling? When you are feeling this way, do you think you would be better off dead or that life is not worth living? Have you been thinking about taking your own life?

The focus of suicide education is to frame the presence of suicidal thoughts as a signal to seek help from a trusted adult.

Treatments for suicide risk are based on rapid access to effective ongoing care for a mental disorder. For self-harm, evidence-based psychotherapies are used.



Confidentiality

When speaking to pupils, ensure that they understand what will and will not remain confidential. Know your professional expectations and the legal parameters in your local authority as well as the policies of your school. Harm to self or others cannot be held in confidence. Remember that any electronic interaction (such as email, texting, etc.) that you have with a student cannot be assumed to be or remain confidential. When speaking with parents, remember that the student may expect confidentiality from parents, parents from student and even parents from each other. Providing information on confidentiality to pupils and parents (for example, on the school website) is useful. Always document your interaction with a student in which a mental health concern has been raised.

What to do?

If you are concerned about a student, involve your school's student services provider (counsellor, social worker, psychologist, etc.) as soon as possible. Discuss the situation and come up with a mutually acceptable plan. Remember that what you are addressing is not your sole responsibility. A teacher is not a diagnostician, is not a counsellor and is not the student's friend. Be careful not to get caught in the problem-solving (teacher becomes responsible for solving the student's problem) or understanding (teacher's role is to understand the student) traps. Provide clear messages about drug use, self-harm and dangerous behaviour. Provide a confidential ear with clear limits to confidentiality.

Teachers should be part of the circle of care that surrounds a student in need. This requires input from teachers and the sharing of necessary information. If your school does not have a process for enlisting appropriate teacher participation in a circle of care, raise this issue with your administration.

For more information on mental health and mental disorders, as well as access to useful (and free) classroom and teacher-friendly resources, visit www.actionforchildren.org.uk/TheGuide or www.teenmentalhealth.org.



WORKING WITH

ACTION FOR CHILDREN

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Teacher Handout

Classroom Exercise for the Beginning of Each Module

Purpose

To teach pupils two useful stress reduction techniques that they can apply in their everyday lives.

Method

Beginning with Module One, when you are introducing the mental health literacy teaching from the Guide tell the pupils that each time that they will be engaging with the mental health literacy materials you will begin the class by leading them through a three to five minute exercise that will help them get their brains and bodies ready to take on the challenges of life, and will help them do that more successfully. The two exercises are outlined below.

Exercise One

The first is Deep Breathing, or also called Box Breathing. If you have internet access you can link to this website (<https://gearpatrol.com/2017/02/02/box-breathing-navy-seals/>) and use the animation it contains. You may want to point out that this is a technique used by elite athletes and elite combat troops to help them perform their best.

Otherwise you can draw this diagram on the board and take the pupils through the exercise.

Have the pupils conduct four or five full cycles of the breathing techniques under your example.

Box Breathing

One useful technique to learn to help with dealing with stress is Box Breathing. It takes about 15 minutes to learn and once mastered can be applied unobtrusively and quietly – ideal for a classroom situation. This technique is described below. Just before beginning the How Do You Cope exercise is a good time to teach the pupils Box Breathing.

Box Breathing can help your heart rate return to normal, which helps you to relax. Here's how you do it: If possible, sit and close your eyes. If not, just focus on your breathing.

Step 1: Inhale your breath (preferably through your nose) for 4 seconds.

Step 2: Hold your breath for 4 seconds. You're not trying to deprive yourself of air; you're just giving the air a few seconds to fill your lungs.

Step 3: Exhale slowly through your mouth for 4 seconds.

Step 4: Pause for 4 seconds (without speaking) before breathing again.

Repeat this process as many times as you can. Even 30 seconds of deep breathing will help you feel more relaxed and in control.

Exercise Two

The second one uses both muscle relaxation and the technique known as centering. We call it the Focus on Your Hands.

Have the pupils make a tight fist with both hands. Tell them to block out paying attention to anything else (including their own thoughts) and attend completely to the sensations that they feel in both fists. Then have them slowly open their fists focusing on how their muscle tension gradually relaxes. When the fist is fully opened have them do two cycles of box breathing while they feel the relaxation in their hands.

Ask your pupils to practice using these techniques at home for 5 minutes everyday. Also ask them to start using these techniques when they are facing a challenge that they need to overcome (such as writing a test, giving a classroom presentation, getting ready for an important meeting or event, etc.). The task here is to become good at these techniques by the time the class reaches Module 6.

Modules

Module 1: The Stigma of Mental Illness

Module 2: Understanding Mental Health and Mental Illness

Module 3: Information on Specific Mental Illnesses

Module 4: Experiences of Mental Illness and the Importance of Family Communication

Module 5: Seeking Help and Finding Support

Module 6: The Importance of Positive Mental Health

The Stigma of Mental Illness

Overview

Many people with mental illness say that the stigma that surrounds mental illness is harder to live with than the disease itself.

Stigma refers to “a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid and discriminate against people with mental illness. Stigma is not just a matter of using the wrong word or action. Stigma is about disrespect. It is the use of negative labels to identify a person living with mental illness. Stigma is a barrier. Fear of stigma and the resulting discrimination discourages individuals and their families from getting the help they need.” (SAMHSA, 2004)

It is important to remember that stigma is not unique to mental illness. Stigma can occur in many different contexts including social and interpersonal relationships such as gender identity, culture, sexual preference, etc. Mental illnesses are not the only illnesses that are or have been the focus of stigma. Some other illnesses that have been the focus of significant stigma include Leprosy, Smallpox, Syphilis, Cancer and HIV/AIDS.

In understanding how to successfully address the stigma of illnesses so that both the stigma and access to effective health care services improves, it is useful to consider how both of these outcomes have occurred in the context of other illnesses. This is summarised below as historical Factors Promoting Stigma and Responses Decreasing Stigma.

The activities in this section will explore the nature of stigma, its impact on the lives of people with mental illness, and some ways of combating stigma.

Factors Promoting Stigma: The Historical Summary

- 1) Linking the illness to religions, moral failings or supernatural causes
- 2) Fear of the impact of the illnesses, including contagion
- 3) Lack of understanding of the causes of the illness
- 4) Lack of effective treatments

Responses Decreasing Stigma: The Historical Summary

- 1) Breaking the link between illness and religions, moral failings, supernatural causes
- 2) Scientific understanding of the causes of the illness
- 3) Investment in scientific research into causes and treatment of the illness
- 4) Widespread access to effective treatments

MODULE 1

Preparation

Learning Objectives

In this module pupils will learn:

- To understand stigma surrounding mental illness, and the impact of stigma on help-seeking behaviour
- To explore the differences between the myths and realities of mental illness
- About some ways of overcoming stigma and promoting a realistic understanding of mental illness

Major Concepts Addressed

- Stigma results in discriminatory behaviour and treatment towards people with mental illness
- The fear of stigma often prevents people from seeking help and treatment for mental illness
- Stigma is perpetuated through mistaken beliefs about mental illness, and can be seen in people's attitudes, in public policy, in the media, etc.
- Stigma can be reduced by providing accurate information about mental illness and its treatment

Teacher Background and Preparation

Read through the activities and preview the videos before class. Choose one video to play for the class.

How-to

If you are using the Community Attitudes Survey (optional) for a homework assignment, hand out a copy of the Community Attitudes Survey and request that pupils survey a minimum of five and a maximum of ten people from the school, their household or the broader community. Remind pupils to bring their results in for the next lesson (Module 2).

Activities

- Activity 1: Defining Stigma (15 min.)
- Activity 2: PowerPoint Presentation: Stigma: Myths and Realities of Mental Illness (10 min.)
- Activity 3: Digital Story Telling (10 min.)
- Activity 4: Which Famous People Lived with a Mental Illness? (10 min.)
- *Activity 5 - Optional Activity: Community Attitudes Survey (homework)*
- *Activity 6 - Optional Activity: Reducing Stigma - What Works? (handout to read at home)*

In Advance

- Make photocopies of the Defining Stigma Handout, one per student
- Support materials

MODULE 1

Preparation

The support materials are located on:
www.actionforchildren.org.uk/TheGuide

The password is: **GuideCymru**

Materials Required

- Handouts for Activities 1 and 4
- Videos - Digital Story Telling
- If using one of the two optional activities you will need those materials as well

Online Supplementary Materials

The supplementary materials are designed to enable you to challenge pupils in your class to learn more about global issues pertaining to stigma. These may or may not be resources that you wish to employ. Please review them and decide if and how you wish to use them.

Talking About Stigma on YouTube (Additional Resources)

TEDxYouth - Kevin Breel: Confessions of a Depressed Comic:
www.youtube.com/watch?v=VYs05qPycYQ

Useful Self-Education

Semantic Scholar: Evidence for effective interventions to reduce mental health-related stigma and discrimination in the medium and long term: systematic review

<https://www.semanticscholar.org/paper/Evidence-for-effective-interventions-to-reduce-and-Mehta-Clement/494d9cb5593143737956c7e381b170e3c5b4f8ca>

Cancer and Stigma: A Brief History
<http://ncbi.nlm.nih.gov/books/NBK12903/>

Note to Teachers

If you are using the Community Attitudes Survey (optional), discuss with pupils the sensitive nature of the questionnaire and warn them that some people they approach might not want to answer it.

Our society often attaches a variety of labels to mental illness - psycho, nuts, crazy, wacko and so on. These terms reinforce the stigma associated with mental illness. In the classroom, it's more appropriate to use the term "person with mental illness".

MODULE 1

Preparation

The following is some general information about Welsh community attitudes towards mental illness and knowledge about mental illness. You can use this information to help guide classroom discussions.

A 2016 survey conducted by ORS on behalf of Time to Change Wales investigated public attitudes towards mental health and mental health stigma. It found the following:

- 1 in 10 people believe that people with a mental illness can never fully recover.
- 1 in 12 people believe that as soon as a person shows signs of mental illness they should be hospitalised.
- 1 in 10 people believe that people with mental health problems are less trustworthy than people without.
- 1 in 7 people believe that people with mental health problems should not be allowed to hold public office.
- 1 in 20 people believe that people with mental health problems should not be given any responsibility.
- 1 in 20 people believe that people with mental health problems should not be allowed to have children.
- 1 in 2 people believe that people with mental health problems are unpredictable.
- 20% of respondents believe that the proportion of the population faced by mental health problems is 1 in 10 or lower.
- 1 in 10 people said that being around someone with mental illness can make them feel uncomfortable.
- 66% of people in Wales would not rent a room in a shared flat to someone with a mental health condition. (2010 YouGov poll commissioned by Time to Change)

The above information underscores how important it is to ensure that young people develop good mental health literacy - not just to help decrease stigma, but to improve all aspects of mental health and care for those who have a mental illness.

What is Mental Health Literacy?

- 1) Understanding how to obtain and maintain good mental health
- 2) Understanding mental disorders and their treatments
- 3) Decreasing stigma
- 4) Enhancing help-seeking efficacy

For more detailed information on mental health literacy, you can read the following:

The Canadian Journal of Psychiatry: Mental Health Literacy: Past, Present and Future
www.ncbi.nlm.nih.gov/pmc/articles/PMC4813415/

European Child and Adolescent Psychiatry: Enhancing Mental Health Literacy in Young People
www.ncbi.nlm.nih.gov/pubmed/27236662

Defining Stigma (15 minutes)

Purpose:

- To explore the meaning of the term stigma and the relationship between attitudes (beliefs) and discriminatory treatment (behaviour and actions) toward people with mental illness.

How-to:

- 1) Ask pupils if they know what the word “stigma” means.
- 2) Provide pupils with the stigma handout and have them review it. Lead a whole-class discussion of the definition of stigma, and the relationship between stigma, stereotyping and discrimination.

Questions to Guide Discussion:

- What are some of the negative things you have heard about people with mental illness? (Possible answers may include: violence, bizarre behaviour)
- What are some of the positive things you have heard about mental illness? (Possible responses may include: link to creativity). While this may be seen as positive, remind pupils that generalising can also be a form of stereotyping.
- Why do you think people with mental illness are stigmatised? (Possible answers include: they are seen as being different, people don't really know the facts about mental illness, etc.)
- Can you think of any other health conditions or social issues that have been stigmatised throughout history? (Possible answers include: homosexuality, Leprosy, AIDS, unwed motherhood, divorce, Cancer, etc.)
- What kinds of factors have contributed to changing public attitudes around some of these conditions or issues? (Possible answers include: education, public policy, open dialogue, scientific research, legislation, changing social norms, better knowledge, etc.)
- What do you think influences perceptions about mental illness? (Possible answers include: the media – films, news, newspaper headlines and stories that associate people with mental illness with violence, the fact that people with mental illness sometimes behave differently, people are afraid of what they don't understand, etc.)
- How do you think stigma affects the lives of people with mental illness? (Possible answers include: people decide not to get help and treatment even though they would benefit from it, it makes them unhappy, they may not be able to get a job or find housing, it may cause them to lose their friends, it puts stress on the whole family, etc.)

Our society often attaches a variety of labels to mental illness which act to reinforce stigma. In the classroom it's more appropriate to use the term “person with mental illness”.

Remind pupils that everyone has some stigmatising or discriminatory thoughts or attitudes, and that the key message here is that we need to recognise those stigmatising or discriminatory thoughts or attitudes, examine where they come from, and work toward changing the hurtful behaviours they cause.

MODULE 1

Activity #1 Stigma Handout

Defining Stigma

The following are definitions of “stigma” taken from different sources and from different historical periods:



A mark or sign of disgrace or discredit; a visible sign or characteristic of disease.
- *The Concise Oxford Dictionary, 1990*

An attribute which is deeply discrediting.
- *Goffman, E. Stigma: The management of Spoiled Identity. 1963*

A distinguishing mark or characteristic of a bad or objectionable kind; a sign of some specific disorder, as hysteria; a mark made upon the skin by burning with a hot iron, as a token of infamy or subjection; a brand; a mark of disgrace or infamy; a sign of severe censure or condemnation, regarded as impressed on a person or thing.
- *The Shorter Oxford Dictionary, Fourth Edition, 1993*



The Stigma of Mental Illness

“Stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid and discriminate against people with mental illnesses. Stigma is not just a matter of using the wrong word or action. Stigma is about disrespect. It is the use of negative labels to identify a person living with mental illness. Stigma is a barrier. Fear of stigma and the resulting discrimination discourages individuals and their families from getting the help they need.” (SAMHSA 2004)

Terms Related to Stigma

Stereotype:

“A person or thing that conforms to an unjustly fixed impression or attitude”

Stereotypes are the attitudes about a group of people (e.g. “All people with mental illness are dangerous”).

Prejudice:

“A preconceived opinion”

Prejudice is agreeing with the stereotypes (e.g. “I think people with mental illness are dangerous”) without knowing or understanding, literally pre-judging.

Discrimination:

“Unfavourable treatment based on prejudice”

Discrimination is a behaviour that may result from stigma (e.g. “I don’t want people with mental illness around me, therefore I discriminate against them by not hiring them, not being friends with them, etc”).

- *The Concise Oxford Dictionary, 1990*

* This activity has been adapted from “Talking About Mental Illness, CAMH 2001

MODULE 1

Activity #2

PowerPoint Presentation: Stigma: Myths & Realities of Mental Illness (10 minutes)

Purpose:

- To debunk the myths of stigma against mental illness.
- To help understand different types of stigma against mental illness.

How-to:

- 1) Use the web version of the presentation by logging on to:

www.actionforchildren.org.uk/TheGuide
The password is: **GuideCymru**

MODULE 1

Activity #3

Video – Digital Story Telling (10 minutes)

Digital Story Telling is the use of a video made by a person to tell others about something important in that person's life. In this module, we have placed a number of these digital stories in which young people living with a mental illness have told their story.

Purpose:

- To provide pupils with an opportunity to learn that a person who has a mental illness is a person. The illness does not define who they are.

How-to:

- 1) Set up the online video to show the class as a whole or arrange small groups at computers to view Digital Story Telling.
- 2) Lead a classroom discussion.

The support materials are located on:
www.actionforchildren.org.uk/TheGuide

The password is: **GuideCymru**

Prior to teaching this module, review each of the videos yourself and choose one or two videos most appropriate for your class. Show the video or videos that you have chosen to the entire class. Support discussions by asking: What is/are the key message(s)? How is the person who is telling the story trying to get their message across? How does what you heard change your ideas about a person living with a mental illness?

Which Famous People Lived with a Mental Illness? (10 minutes)

Purpose:

- To help pupils understand that the presence of a mental illness does not mean a person cannot have a successful life and make a positive contribution to society.
- To demonstrate that people from all walks of life and throughout history have been successful while living with a mental illness.

How-to:

- 1) From the following list of names assign pupils to research one person.
- 2) Have pupils complete the following chart for each person named that they will be researching.

Name of Person	Area of Greatest Contribution	Type of Mental Illness
List of Names (feel free to add others from your own research): Abraham Lincoln; Winston Churchill; Carrie Fisher; Dorothy Hamill; Clara Hughes; Demi Lovato; Jared Padalecki; Megan Fox; Pete Wentz; David Beckham; JK Rowling; Brittany Snow; Josh Ramsay; Leo Tolstoy; Virginia Woolf; Ernest Hemmingway; Margot Kidder; Margaret Trudeau; Ludwig van Beethoven; Patty Duke; Karen Carpenter; Boris Yeltsin; Britney Spears; Charles Darwin; John Nash; Janet Jackson; Buzz Aldrin; Terry Bradshaw; Marlon Brando; Jim Carrey; Robin Williams; Sheryl Crow; Kurt Cobain; Calvin Coolidge; Princess Diana; Tipper Gore; John Daly; Emma Stone; Leonardo Dicaprio; Justin Bieber; Michelangelo; Issac Newton; Vincent Van Gough; Pablo Picasso; Martin Luther King Jr.; Patrick Kennedy; Keira Knightley; Catherine Zeta-Jones; Brooke Shields; Jean-Claude Van Damme; Michael Phelps, Mariah Carey.		

- 3) Have pupils present their findings to the class.

MODULE 1

Activity #5 (Optional)

Community Attitudes Survey (Homework)

Purpose:

- To analyse the results of the survey handout completed by pupils and discuss in class.
- Draw conclusions about the community's awareness of mental illness.

How-to:

- 1) In groups of four or five, pupils share survey responses to get a better picture of the attitudes of the larger sample. If time permits (or as a possible follow up project for those who are interested), pupils could use computer programs to collate and graph the survey results.
- 2) Ask pupils to come up with some general conclusions from the grouped survey findings to share with the rest of the class, for example:
 - Our sample was not well informed about mental illnesses because X% responded...
 - The women in our sample were more tolerant about mental illness than the men
 - Only half the people surveyed agreed that they would have someone with a mental illness as a close friend
- 3) Facilitate a class-wide discussion about the survey results, highlighting ways in which the results inform us about peoples' attitudes about mental illness. Refer to the Community Attitudes Survey: Best Answers (Modified), to ground the discussion and answer any questions that pupils might have. Use the sample questions below as a guide for discussion.

Sample Questions:

- What do the responses tell you about the level of awareness about mental illness in the community?
- What role do you think the media plays in shaping peoples' attitudes?
- Do you think your results reflect Wales-wide community attitudes more generally? Why or why not?
- Do you think it's possible to change community attitudes toward mental illness? How might this be done?

MODULE 1

Activity #5 Survey Handout

Check the most appropriate answer	Agree	Disagree	Not sure
People should work out their own mental illness			
Once you have a mental illness, you usually have it for life			
Females are more likely to have a mental illness than males			
Medicine should never be used to treat a mental illness			
People with a mental illness are usually violent and dangerous			
Most mental illnesses can be diagnosed before age 25			
You can tell by looking at someone whether they have a mental illness			
People with a mental illness are generally shy and quiet			
Mental illness can happen to anybody			
You would be willing to have a person with a mental illness at your school or at your work			
You would be happy to have a person with mental illness become a close friend			

Respondent	M/F	Under 19	20-29	30-39	40-49	50 and up
#1						
#2						
#3						
#4						
#5						
#6						
#7						
#8						
#9						
#10						

*Adapted from *MindMatters: Understanding Mental Illness*, pg. 57.

MODULE 1

Activity #5 Handout

Community Attitudes Survey: Best Answers (Modified)

1) People should work out their own mental illness

Not true. When people have a physical health concern, they generally take some action, and often go to the doctor. Mental illness is associated with disturbances with brain functioning and usually requires professional assistance. Because of the stigma surrounding mental illness many people have been reluctant to seek help.

2) Once you have a mental illness, you usually have it for life

While it's true that most mental illnesses are lifelong, they are often episodic. This means that the symptoms are not always present. Just like people who live with chronic physical illnesses like arthritis and asthma, people with mental illnesses can, when their illness is managed, live positive and productive lives.

3) Females are more likely to have a mental illness than males

Men and women are both equally affected by mental illnesses in general, but there may be higher rates among women of specific illnesses such as eating disorders. There may sometimes be higher rates in women for other disorders such as Depression. Men have higher rates for some disorders such as alcoholism and ADHD. Some illnesses are relatively equally shared by both men and women (e.g. Bipolar Disorder).

Women are more likely to seek help for mental and emotional difficulties and to share their concerns with friends compared to men. Females are more willing to let friends know if they are receiving counselling.

4) Medicine should never be used to treat a mental illness

Medication can be a very effective part of treating a mental illness, but it is not always the best nor only type of treatment. For many people with a mental illness it is a necessary part of their care. A wide range of appropriate interventions, including medication, counselling, social, vocational and housing-related supports, as well as self-help and generic resources for all community members (such as: groups, clubs, and religious institutions) may also be important in helping people recover and stay well.

It is helpful to think of medications as often necessary but not sufficient treatments for many mental disorders. The best approach is to have a combination of strategies that have been scientifically proven effective.

5) People with a mental illness are usually violent and dangerous

People with mental illness are generally not more violent than the rest of the population. Mental illness plays no part in the majority of violent crimes committed in our society. The assumption that any and every mental illness carries with it an almost certain potential for violence is not correct. However, a small number of people who have a mental illness where they may have lost their ability to distinguish what is real and what is not real may commit an unusual, violent act. This can be unusual and is therefore sensationalised in the media, leading to the mistaken belief that all people who have a mental illness are violent.

6) Most mental illnesses can be diagnosed before age 25

Many of the major mental illnesses begin to appear during adolescence and early adulthood. About 70% of all mental illness can be diagnosed by age 25.

Community Attitudes Survey: Best Answers (Modified) (cont.)

7) You can tell by looking at someone whether they have a mental illness

Generally, you can't tell if a person has a mental illness based on their appearance. Sometimes, when people are experiencing an acute episode of their illness, their behaviour may be bizarre, especially if they are experiencing an episode of psychosis.

8) People with a mental illness are generally shy and quiet

There is no causal relationship between personality characteristics and tendency to develop mental illness. Some mental disorders such as Depression and Anxiety Disorder can lead people to avoid or limit social contact.

9) Mental illness can happen to anybody

This is correct. In fact, it's very likely that you, a family member or someone you're close to will experience a mental illness at some point in their lives.

10) You would be willing to have a person with a mental illness at your school or at your work

See answer to question 11 below.

11) You would be happy to have a person with mental illness become a close friend

Questions 10 and 11 both address the issue of "social distance" - that is, the willingness to engage in relationships of varying intimacy with a person. Social distance is an indicator of public attitudes toward people with mental illness.

Social distance is a complex concept influenced by a number of factors, including age, gender, socio-economic and cultural factors, but also by the respondent's general attitude toward mental illness.

Contact, or social inclusion of people with mental illness with the rest of the population, is one factor that may lead to a decrease in stigma. This can happen when people find out that a coworker, neighbour or friend is struggling with mental illness, and despite it, is living on their own, working and being a part of the community.

MODULE 1

Activity #6 (Optional)

Handout: Reducing Stigma - What Works? (10 minutes)

Purpose:

- To provide pupils with practical ideas about what they can do to reduce the stigma of mental illness in their everyday lives.

How-to:

- 1) Distribute the handout and encourage pupils to apply the strategies for reducing stigma in the school, at home, and in the community.
- 2) Remind pupils that things have improved since the days of the “looney bin”; however, there are still many examples of how people living with mental illness are portrayed as violent as well as ridiculed in the media and popular culture. Have pupils think about topical stories from the news and/or movies and TV shows.
- 3) Ask pupils to take the handout home to read it and if possible discuss with their parents or other adults.
- 4) For those pupils who are interested in more active advocacy, help them draft a letter to their local politician: mayor, city councillor, member of legislative assembly, member of parliament, etc.

Reducing Stigma – What Works?

There is no simple or single strategy to eliminate the stigma associated with mental illness, but some positive steps can be taken. Research is showing that negative perceptions about severe mental illness can be changed by:

- **Providing information based on reliable research** that refutes the mistaken association between violence and severe mental illness and that presents the scientifically-based causes of mental illness.
- **Effective advocacy and public education programs** can help to shift attitudes and contribute to the reduction of stigma.
- **Proximity or direct contact with people with mental illness** tends to reduce negative stereotypes.
- **Programs that help people to become better integrated in the community** through school, work, integrated housing, or interest-based social groups not only serve to promote the individual's mental health by reducing exclusion, but also can play a part in gradually shifting commonly-held negative attitudes.
- **Treatments and supports** that work to help people recover.
- **Better mental health literacy** is important. Understanding mental illness and their treatments is an important counterbalance to uninformed opinion.

LEARN MORE ABOUT MENTAL ILLNESS

If you are well-informed about mental illness, you will be better able to evaluate and resist the inaccurate negative stereotypes that you come across.

LISTEN TO PEOPLE WHO HAVE EXPERIENCED MENTAL ILLNESS

These individuals can describe what they find stigmatising, how stigma affects their lives and how they would like to be viewed and treated.

WATCH YOUR LANGUAGE

Most of us, even mental health professionals and people who have mental illness, use terms and expressions related to mental illness that may perpetuate stigma.

RESPOND TO STIGMATISING MATERIAL IN THE MEDIA

Keep your eyes peeled for media that stigmatises mental illness and report it to any number of Organisations. Get in touch with the people - authors, editors, movie producers, advertisers responsible for the material. Write, call or email them yourself, expressing your concerns and providing more accurate information that they can use.

SPEAK UP ABOUT STIGMA

When someone you know misuses a psychiatric term (such as Schizophrenia, Bipolar Disorder, OCD, etc.), let them know and educate them about the correct meaning. When someone says something negative about a person with mental illness, tells a joke that ridicules mental illness, or makes disrespectful comments about mental illness, let them know that it is hurtful and that you find such comments offensive and unacceptable.

MODULE 1

Activity #6 Handout

TALK RESPONSIBLY ABOUT MENTAL ILLNESS

Don't be afraid to let others know of your mental illness or the mental illness of a loved one. The more mental illness remains hidden, the more people continue to believe that it is a shameful thing that needs to be kept hidden. However, remember that not all talking is useful. Talk in an informed way. TALK SMART!

DEMAND CHANGE FROM YOUR ELECTED REPRESENTATIVES

Policies that perpetuate stigma can be changed if enough people let their elected representatives (e.g. local and national members of parliament) know that they want such change.

PROVIDE SUPPORT FOR ORGANISATIONS THAT FIGHT STIGMA

Join, volunteer, or donate money. The influence and effectiveness of organisations fighting the stigma surrounding mental illness depend to a large extent on the efforts of volunteers and on donations. You can make a contribution by getting involved. But, before you join make sure that what the organisation is doing has been proven to be helpful. Ask your teacher for information to help you with this decision.

GET ACTIVE

Changing stigma is important but it is not enough. Our health systems are often structured or funded in such a way as to make rapid access to effective mental health care difficult for those who need it. So, here is an evidence to action activity that you can apply.

- 1) Find out how long the wait list for mental health care is in your community
- 2) Find out who the politicians are in your community
- 3) Write a class letter to your local politicians pointing out the need to improve access to effective mental health care for young people who need it

Understanding Mental Health and Mental Illness

Overview

While most young people have heard about mental health, many do not know about nor understand mental health and mental illness. In fact, many confuse the terms mental health and mental illness and often use terms from mental illness to describe normal life (such as “I am traumatised” for “I am upset”; “I am depressed” for “I am unhappy”; “I have OCD” for “I am tidy”; etc.). And, many do not know that both mental health and mental illness are the result of how our brains function. Before thinking about the problems that occur in the brain when someone has a mental illness, it is helpful to think about how the brain functions in health.

In this module, pupils will be introduced to the basics of brain function, and will learn that the brain processes and reacts to everything we experience. Its activities initiate and control movement, thinking, perception, emotions and involuntary physiological processes. Pupils will learn that brain function determines both mental health and mental illness, and that the two are not mutually exclusive.

Learning Objectives

In this lesson pupils will learn:

- Some of the basic concepts involved in normal brain function, and the role the brain plays in controlling our thoughts, feelings and behaviours
- That mental health and mental illness both include a wide range of states
- That having a mental health problem is not the same thing as having a mental illness
- That a person can have a mental illness and be mentally healthy at the same time
- Some of the language used to discuss mental health and mental illness

Major Concepts Addressed

- Everyone has mental health regardless of whether or not they have mental illness
- The brain is responsible for cognition, perception, emotions, physical functions, emotional response (reactions to the environment) and behaviours
- Changes in brain function lead to changes in thoughts, feelings and behaviours that can last a short or long time
- A mental illness affects a person’s thinking, feelings or behaviour (or all three) and causes that person difficulty in functioning
- Mental illnesses have complex causes including a biological basis and are therefore not that different from other illnesses
- As with all illnesses, the sooner people get help and receive effective treatment for mental illness, the better their long and short-term outcomes
- Many of the major mental illnesses begin to emerge during adolescence which is why it is so important to learn about them now

MODULE 2

Preparation

Teacher Background

- Read through the activities and definitions provided. Ensure that you have a good grasp on the meaning of the terms and how they relate to the triangle diagram. It would be useful to review the short video explanation of the triangle diagram, which can be found in the Resources Appendix.
- Preview Part 1 of the PowerPoint Presentation: Understanding Mental Health and Mental Illness
- Watch the Brain Video: <https://www.youtube.com/watch?v=EGdIpaWi3rc>
- Watch the Inter-Relationship of Mental Health States: Language Matters Video: <https://www.youtube.com/watch?v=LsowyMnqCRs&t=31s>

Activities

- Activity 1: Teenage Brain (10 min.)
- Activity 2: PowerPoint Presentation: Understanding Mental Health and Mental Illness (20 min.)
- Activity 3: Language Matters (25 min.)
- *Optional Activity - Activity 4: Language in the Media (homework)*

In Advance

- Set up computers or projector to show PowerPoint presentation
- Photocopy handouts for Activity 3, one for each student

Materials Required

- Handout Activity 3 Definitions
- Flip chart paper, markers and tape

Online Supplementary Materials

The supplementary materials are designed to challenge pupils to learn more about the brain. Please review these resources to decide if and how you will use them in your class.

Useful Self-Education

TeenMentalHealth.Org: The Teen Brain
www.teenmentalhealth.org/the-teen-brain-2/

Alberta Family Wellness Foundation: Brain Video
<http://www.albertafamilywellness.org/what-we-know/the-brain-story>

National Science Foundation
www.nsf.gov/news/special_reports/brain/

Center for Educational Research and Innovation: Understanding the Brain
www.oecd.org/site/educeri21st/40554190.pdf

Bozeman Science: The Brain
www.youtube.com/watch?v=kMKc8nfPATI

MODULE 2

Activity #1

Teenage Brain (10 minutes)

Purpose:

- To introduce pupils to the importance of understanding the function of the brain as a basis for human growth and development and to promote pupil interest in learning about the brain.

How-to:

- 1) Tell the class you will be playing a video about the teenage brain – one of the most amazing things in the world.
- 2) Play the video.
- 3) Ask the pupils to choose one thing that they learned from the video that they would want to share with a friend, a parent or a family member. Have some of the pupils share what that was and why with the class.

MODULE 2

Activity #2

Mental Health and Mental Illness: The Common Basis (20 minutes)

Purpose:

- To provide an introduction to basic brain functioning for pupils to help them understand that the brain controls cognition, perception, emotions, physical functions, emotional response (reactions to the environment) and behaviours.
- To illustrate that mental health and mental illness are related to each other, and that they are not mutually exclusive.
- To show that some changes in brain function cause changes in thoughts, feelings and behaviour that can last a short or a long time.

How-to:

- 1) Use the web version of the PowerPoint presentation by logging on to:

www.actionforchildren.org.uk/TheGuide

The password is: **GuideCymru**

- 2) Show the PowerPoint presentation.
- 3) Discuss with the class. What did they learn? What would they want to share with a friend?

Language Matters (25 minutes)

Purpose:

- To help understand how the words that we use can help us better understand what mental health state category we or others are in.
- To learn how to use specific words to more clearly describe how we are feeling.

How-to:

- 1) Provide the pupils with the Handout (Understanding the Words) which is found below and in the Resource Appendix. Give the class about 10 minutes to read the handout.
- 2) Provide the class with the following list of words (found below), which all describe emotional states.
- 3) Prepare four sections along the wall of the classroom (or four different flip charts) with each titled as one of the four different mental health states (no distress, problem, or disorder, mental distress, mental health problem, mental disorder).
- 4) Have each student write each word on a sticky note corresponding to the mental health state category that they think best captures the meaning of the word.
- 5) Once they are finished, have pupils place their words in the mental health state categories as you have prepared them.
- 6) Discuss which words are most commonly used for each category and why some words may be less appropriate for certain categories.

Word List Describing Various Emotional States

Upset	Disgusted	Heartbroken	Forlorn
Annoyed	Demoralised	Down	Pensive
Sad	Angry	Sorry	Thoughtful
Unhappy	Bitter	Sorrowful	Disconsolate
Disappointed	Blue	Glum	Distressed
Despondent	Depressed	Dejected	Pessimistic
Mournful	Despairing	Depression	Irritated

Note: Here the word “Depression” would be used to denote the mental illness of Depression while the word “depressed” would be used to denote a negative emotional state which may better fit in the category of mental health problem.

What Does it Mean?

If pupils do not know the meaning of a word, they need to find out as part of this activity.

Note to teachers: Please make the definitions and the triangle diagram handout available as a student handout for this module.

MODULE 2

Activity #3 Handout

Definitions

Mental Health

There are many different definitions of mental health. They all try to capture one important thing. That is, that a healthy brain is what gives us mental health. The brain is an important part of the body and the body and brain are linked. It is really not possible to consider them separately. We know that what is good for your body will be good for your brain as well, and vice-versa.

Basically, mental health means having the capacity to be able to successfully adapt to the challenges that life creates for people. These challenges are both positive and negative. In order to adapt to them our brains need to apply all of their capacities of: emotions, cognition/thinking, emotional response functions and behaviours. Our brains learn how to apply these capacities over time and as we grow and develop we are able to take on more and more challenges and become successful in dealing with them.

Sometimes people forget that negative emotions are a part of good mental health. Crying, feeling sad, getting annoyed or angry, etc. are all normal responses to life challenges. So are negative thoughts such as: “this is too hard for me” or “I am not a good person” or “people don’t like me”. So are negative behaviours, such as yelling at somebody or avoiding a situation that makes us feel stressed. Just because we feel stressed does not mean that we don’t have good mental health. Indeed, being able to identify stress and learn how to successfully overcome it in a way that solves the problem causing it is fundamental to having good mental health.

For example: feeling stressed about writing an examination could lead to a negative behaviour – such as going out to party with friends to drink and “forget” about the stress. Or it could lead to a neutral behaviour – such as going for a run or meditating to “release” the stress but not studying for the exam. But if that is your entire adaptive response you likely will not do well on your exam. The important coping strategy that your stress response should be eliciting from you here is to study or to get help from your teacher to assist you in understanding something that you may not know very well. If you add this coping strategy to your stress “releasing” activity you will be much more likely to succeed and that is a sign of good mental health. More on this important topic in Module 6.

It is important to understand that everyone has mental health just like everyone has physical health. And, just like a person can have good physical health and at the same time have a physical illness, people can have good mental health and a mental illness at the same time.

To understand mental health it is necessary to understand the three related components of mental health: mental distress, mental health problems and mental disorder. These are illustrated in the triangle diagram.

Mental Distress

Mental distress is the inner signal of anxiety or “stress” that a person has when something in their environment is demanding that they adapt to a challenge (for example: writing a test, giving a presentation in front of the class, asking a person to go out on a date, failing to make a school sports team, etc.). This is called a “stress signal” or “stress response”. A stress signal has different components to it: emotions/feelings (such as worrying, unhappiness, feeling energised, annoyance), cognitions/thinking (negative thoughts such as “I am not good at anything”, “I wish I did not have to do this”, or positive thoughts such as “this is something I need to solve”, “it may be difficult but I can do this”, “I should ask my friend for their advice”), physical symptoms (such as stomach aches and headaches, the stomach “butterflies”) and behaviours (such as avoidance of the situation, engagement of the challenge, positive energy, withdrawal from others, yelling at someone or helping someone). As we can see, the response to distress can have both negative and positive components! We need to make sure we don’t always focus on the negative ones.

MODULE 2

Activity #3 Handout

Everybody experiences mental distress (often called “stress”) everyday. It is a part of good mental health. It is a signal that tells us to try something new to solve the challenge we are facing. As the person who feels distress tries to develop solutions or strategies to solve the challenges (often called “stressors”) they figure out what works and what does not work well. Successfully dealing with the stressor (also called solving the problem) leads to learning what strategy worked and use of that strategy in similar situations in the future. Once the person has successfully overcome the challenge, the distress goes away. But the learning and skill sets remain, ready to be used another time. This process is called adaptation or resilience building.

Young people experiencing everyday mental distress do not require counselling, they are not “sick” and they do not need treatment. They most often learn how to manage stress and how to use the “stress signal” to develop new skills. They learn these skills by trial and error, by obtaining advice from friends, parents, teachers and trusted adults and from other sources (such as the media). They can also use techniques that are part of general health management, such as: exercise, having enough sleep, being with friends and family, eating properly and staying away from drugs and alcohol. Sometimes what the young person tries does not work (for example: instead of studying for an exam they go out and party with their friends, instead of getting a good night’s sleep before an exam they try to stay up all night and study) and as a result their distress may increase. But making wrong choices is part of learning how to make good choices. This is a normal part of growing up. Allowing young people to avoid everyday mental distress, or to focus only on teaching them how to modulate the stress response instead of how to use it to learn new skills, can have negative impacts on their development of skills that they need to learn in order to have successful adult lives.

Mental Health Problems

Mental health problems may arise when a person is faced with a much larger stressor than usual. These occur as part of normal life and are not mental illnesses. For example: death of a loved one, moving to a new country, having a serious physical illness, etc. When faced with these large stressors, everyone experiences strong negative emotions (such as: sadness, grief, anger, demoralisation, etc.). These emotions are also accompanied by substantial difficulties in other domains such as: cognitive/thinking (for example: “nothing will ever be the same”, “I don’t know if I can go on in my life”, etc.), physical (for example: sleep problems, loss of energy, numerous aches and pains), and behavioural (for example: social withdrawal, avoidance of usual activities, angry outbursts, etc.).

Sometimes the young person experiencing a mental health problem will exhibit noticeable difficulties in everyday functioning - at school and outside of school. In addition to the distress, management skills and general health enhancing activities that are useful in decreasing mental distress, young people experiencing a mental health problem will often need additional support to help them through the difficult situation or assist them with problems in functioning (such as extra time for academic activities, time away from school to be with their families, etc.). In such cases, this support can come from a counsellor, a religious leader, or another person that has the skills needed to help effectively. Medical treatment (medication or psychotherapy) is usually not necessary. The presence of a supportive adult (such as a teacher or neighbour) is a key component that can help young people deal with mental health problems.

Mental Illness

A mental illness is very different from mental distress and from a mental health problem. It arises from a complex interplay between a person’s genetic makeup and the environment in which they live or have been exposed to at different times in their lives. A mental disorder (also called a mental illness) is a medical condition diagnosed by a psychiatrist or registered health professional that has had additional training in children’s mental health using internationally established diagnostic criteria. A person with a mental disorder is best helped by a trained health professional providing best evidence-based treatments. Mental illnesses are the result of changes that arise in usual brain function as a result of a complex interplay between a person’s genes and environment. When a person has a mental disorder, their brain is not working as it should be.

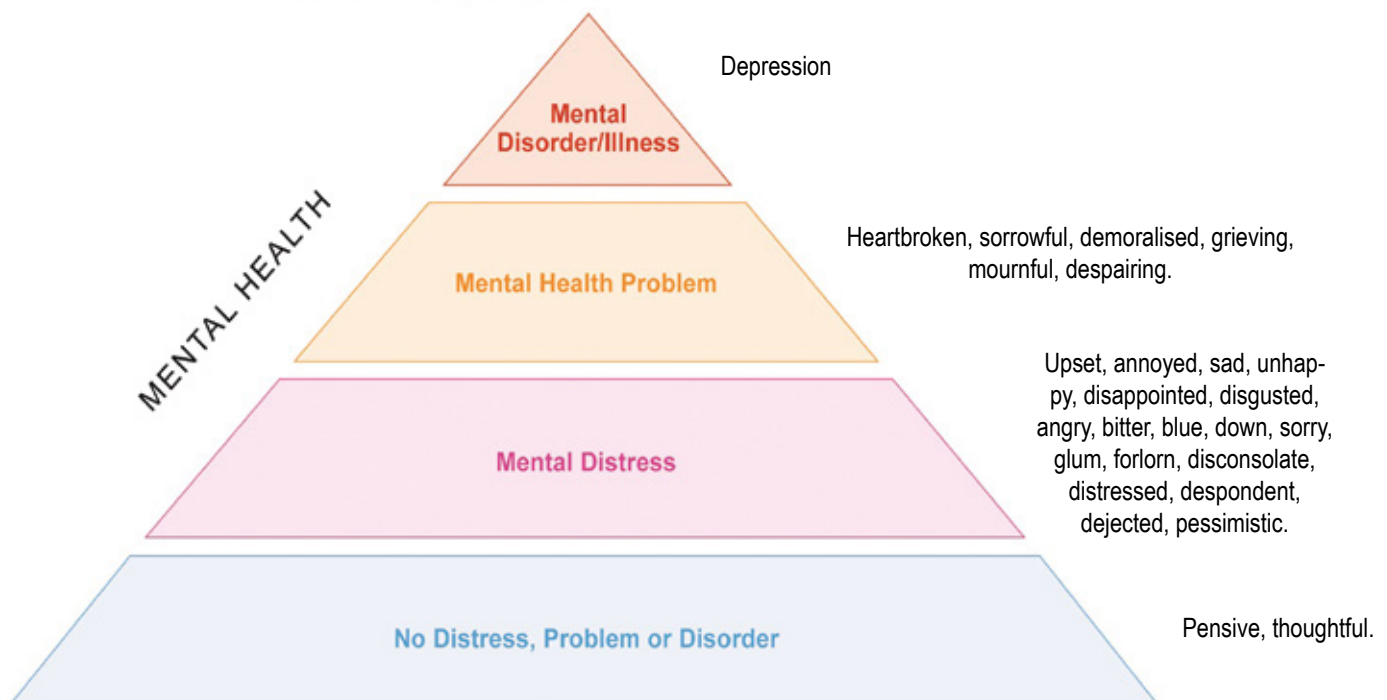
MODULE 2

Activity #3 Handout

A person with a mental illness will experience significant, substantial and persistent challenges with emotions/feelings (for example: Depression, panic attacks, overwhelming anxiety, etc.), cognition/thinking (delusions, disordered thoughts, hopelessness, suicidal thoughts, etc.), physical (for example: fatigue, lethargy, excessive movement, etc.), and behaviour (for example: school refusal and withdrawal from family and friends, suicide attempt, poor self-care, etc.). The presence of a mental disorder signifies that an individual needs best evidence-based interventions that may be of many different types (such as medications, psychotherapies, social interventions, etc.), provided by appropriately trained health care providers. While interventions that can help distress and mental health problems can also be used to help a person who has a mental illness, and general health enhancing activities are always useful, a young person with a mental disorder requires a degree of care above and beyond that usually provided for a mental health problem. Mental disorders always require treatment using best evidence-based care by trained health professionals (such as: registered mental health practitioners, doctors, psychiatric nurses, psychologists, etc.).

And: a person can be in each of these states at the same time. For example, over the course of one day a person can be laughing and having fun with their friends (no distress, problem or disorder), can experience distress (lost their house key), be experiencing a mental health problem (their uncle with whom they were close died earlier this week), and have a mental disorder (such as Attention Deficit Hyperactivity Disorder).

THE INTER-RELATIONSHIP OF MENTAL HEALTH STATES: LANGUAGE MATTERS



Check out Dr. Kutcher's video blog, *The Inter-Relationship of Mental Health States: Language Matters* at: <https://www.youtube.com/watch?v=LsowyMnqCRs&t=1s>

MODULE 2

Activity #3

Note to teachers:

- *Mental health states are not a continuum. People do not usually progress from mental distress to illness.*
- *People can experience one or more states at the same time. A person can have good mental health and a mental illness concurrently.*
- *Different mental health states should be dealt with differently. For example, daily mental distress may not need any intervention. People are able to adapt by themselves with support from the family or community. People with mental health problems may need extra professional help, such as counselling, in addition to family and community support. People with mental disorders require best evidence-based care from properly trained health care providers.*

MODULE 2

Activity #4 (Optional/Homework)

Language in the Media

Purpose:

- To help pupils critically evaluate how the media can either positively promote or mislead audiences when it comes to mental health and mental illness.

How-to:

- 1) Ask pupils to find a news story about mental health or mental illness and read it.
- 2) Have pupils critically evaluate the language used. Did the story clearly differentiate between mental health and mental illness? Did the story use terms that were vague or confusing?
- 3) Have pupils write a one page review of the news story addressing the above issues.

Information on Specific Mental Illnesses

Overview

In this module, pupils will learn more about the most common mental illnesses that affect adolescents.

This module is divided into 3 sections – A, B and C. For each section, each activity must be completed. There are no optional activities in this module. Module 3 can be completed over two or more classroom periods if necessary. All required resources can be found at www.actionforchildren.org.uk/TheGuide.

Learning Objectives

In this lesson pupils will learn to:

- Recognise that mental illnesses are associated with changes in usual brain functions
- Gain a better understanding of the symptoms, causes, treatments and other supports for specific mental illnesses that commonly arise during adolescence

Major Concepts Addressed

- A mental illness changes many aspects of a person's life (cognition, perception, emotions, physical functions), emotional responses (reactions to the environment and behaviours) and causes that person difficulty in functioning
- Mental illness describes a broad range of conditions (the type, intensity, and duration of symptoms of mental illnesses vary)
- The exact cause of mental illnesses are not known, but most experts believe that, like with other illnesses, a combination of biological and environmental factors are involved
- Like illnesses that affect other parts of the body, mental illnesses are treatable, and the sooner people receive proper treatment and supports, the better the outcomes
- With a variety of supports, most people with mental illness recover and go on to lead fulfilling and productive lives

Teacher Background and Preparation

- Read through the information sheets for Activity 2 on mental illnesses prior to the class
- Preview the PowerPoint presentations
- Review Teacher Knowledge Update
- Read each of the five "Mini Mags"
- Review each of the five animated videos (check out the Resources Appendix for a video "walk through" of the animated videos)
- Watch the Environmental and Genetic Factors Influence on the Brain Video:
<https://www.youtube.com/watch?v=hOugfw1T26A>

MODULE 3

Preparation

Activities

- Activity 1: PowerPoint Presentation: What Happens When the Brain Gets Sick? (20 min.)
- Activity 2: PowerPoint Presentation: Common Mental Illnesses (25 min.)
- Activity 3: Understanding Common Mental Disorders Found in Teenagers (45 min.)
- Activity 4: Discussion Groups (25 min.)
- Activity 5: Sharing the Pieces (20 min.)

In Advance

- Preview both PowerPoint presentations
- Obtain animated video links for ADHD, Depression, Panic Disorder, Social Anxiety Disorder and Obsessive Compulsive Disorder
- Obtain links to each of the Mini-Mags if handing out to pupils: <http://teenmentalhealth.org/product/teenmentalhealth-speaks-magazine/>

Materials Required

- PowerPoint presentations

Online Supplementary Materials

Sun Life Financial Chair in Adolescent Mental Health: “TMH Speaks... Mini Mags” Series
www.teenmentalhealth.org/product/teenmentalhealth-speaks-magazine/

- National Centre for Mental Health: <https://www.ncmh.info/>
- National Health Service: <https://www.nhs.uk/>
- National Institute of Mental Health: <http://www.nimh.nih.gov/health/topics/index.shtml>
- Royal College of Psychiatrists: <https://www.rcpsych.ac.uk/>
- Teen Mental Health: www.teenmentalhealth.org

Useful Self-Education

Merck Manuals Consumer Version

www.merckmanuals.com/home/mental-health-disorders/overview-of-mental-health-care/overview-of-mental-illness

PowerPoint Presentation: What Happens When the Brain Gets Sick? (20 minutes)

Purpose:

- The PowerPoint “What Happens When the Brain Gets Sick?” provides an overview of how the six different brain functions change between a healthy brain and when a mental illness occurs.
- Pupils should understand that a mental disorder is due to changes in usual brain function.

How-to:

- 1) Present the PowerPoint “What Happens When the Brain Gets Sick?” from the web to your class.

www.actionforchildren.org.uk/TheGuide

The password is: **GuideCymru**

- 2) Have the pupils write a one paragraph report on the following:

Choose one important piece of information that you learned from this lesson and discuss how you will:

- a) Share that important information with a friend
- b) Use it to help you improve your own health

Note to teachers:

You may want to provide your pupils with the questions in “How-to” before starting the PowerPoint presentation so that they can consider their responses while they are listening to your presentation.

MODULE 3A

Activity #2

PowerPoint Presentation: Common Mental Illnesses (25 minutes)

Purpose:

- The PowerPoint “Common Mental Illnesses” provides an overview of the common mental illnesses.

How-to:

- 1) Present the PowerPoint “Some Common Mental Illnesses In Young People” from the web to your class.

www.actionforchildren.org.uk/TheGuide

The password is: **GuideCymru**

- 2) Lead a class discussion about the materials presented in both PowerPoint presentations. Consider these questions:
 - a) What did you learn from the presentations?
 - b) How does the function of our brains lead to good mental health?
 - c) How does change in various brain function show itself?
 - d) How would you use what you learned in Module 2 and this part of Module 3 to teach friends or family about the brain and its functions?
 - e) How can what you learned today be used to help decrease stigma about mental disorders?
 - f) What did you learn today that you can use in your own life to help keep you healthy?

Understanding Common Mental Disorders Found in Teenagers (45 minutes)

Purpose:

- To provide a solid understanding of the five most common mental disorders that are found in teenagers: ADHD, Depression, Panic Disorder, Social Anxiety Disorder and Obsessive Compulsive Disorder.

How-to:

- 1) Distribute copies (or URL links) of the Mini Mags on each of the five disorders to the pupils.
- 2) Play each of the animated videos to the class. After each animated video, have the class discuss what they saw. Ensure that for each video the difference between normal emotional states and the illness is clear. Ensure that the metaphor for understanding each is clear. Ensure that treatment for each illness is clear (for ADHD, this will require the teacher providing the interpretation).
- 3) Have pupils read the Mini Mags.
- 4) Have pupils write down one new piece of information learned from each video and submit to you upon completion of this activity.

MODULE 3C

Activity #4

Discussion Groups (25 minutes)

Purpose:

- To provide information about various common mental disorders.
- To have pupils learn about these disorders and share their learning with others.

How-to:

- 1) Form the class into eight groups. Assign each group one of the mental disorders and distribute the appropriate Fact Sheet for that disorder to each group member. Provide each group with the Reporting Page for the disorder.
- 2) Explain to pupils that a jigsaw puzzle activity will be used during this lesson. This means that pupils will work in small groups and will become resource persons about one mental illness (one piece of the jigsaw). Each group member will read the assigned disorder Fact Sheet. Then each group will collaborate to complete their Reporting Page. After completing the Reporting Page on their specific illness together, they will choose a group reporter who will share their information with the rest of the class (Activity #5).
- 3) Give the groups time to read the Fact Sheets and direct them to the online “TMH Speaks ... Mini Mags” series at <http://teenmentalhealth.org/product/teenmentalhealth-speaks-magazine/>. When they have finished reviewing, ask each group to complete their Reporting Page on the mental disorder they were assigned.
- 4) Have each group complete the handouts to share with others during the next activity.

Group #1: Anxiety Disorders (Fact Sheet)

What is Anxiety?

Anxiety is a state of constant physical, emotional and cognitive hyperarousal. It is sometimes confused with the stress response (see Module 6) and the term is often incorrectly used to describe how one feels when faced with a challenging or dangerous situation. The word to describe that sensation is “fear”.

When people say that they are anxious they cite feeling upset, uncomfortable and tense and may experience many physical symptoms such as stomach upset, shaking and headaches.

It is essential to differentiate the expected stress response symptoms to normal or casual life challenges from Anxiety Disorders. Sometimes the language used confuses the two. For example, the phrase “examination anxiety” can be interpreted to mean an Anxiety Disorder caused by exposure to an examination. This is not correct. The phrase “examination induced stress response” conveys a more useful explanation of the phenomenon being described.

What are Anxiety Disorders?

The Anxiety Disorders are a group of illnesses, each characterised by persistent feelings of intense anxiety. There are continuous feelings of extreme discomfort and tension, and may include panic attacks. This anxiety exists in and of itself. It does not arise as a result of a change in the person’s environment. However, the symptoms of anxiety found in an Anxiety Disorder can be increased or intensified in stress-provoking situations.

People are likely to be diagnosed with an Anxiety Disorder when their level of anxiety symptoms or feelings of panic are so extreme that they significantly interfere with daily life and stop them from doing what they want to do.

Anxiety Disorders affect the way the person thinks, feels and behaves and, if not treated, can cause considerable suffering and life difficulties. They often begin in adolescence or early adulthood. People with an Anxiety Disorder also usually show much more anxiety when faced with an everyday environmental challenge compared to a person without an Anxiety Disorder.

Anxiety Disorders are common and may affect one in twenty people at any given time.

Anxiety Disorders: What are the Main Types of Anxiety Disorders?

All Anxiety Disorders are disturbances of the brain’s emotional response functions and are characterised by heightened everyday symptoms of anxiety or panic as well as significant problems in everyday life.

Generalised Anxiety Disorder

People with this disorder worry constantly about themselves or their loved ones, financial disaster, their health, work or personal relationships. These people experience continuous apprehension and often suffer from many physical symptoms such as headache, diarrhoea, stomach pains and heart palpitations.

MODULE 3C

Activity #4 Handout

Agoraphobia

Agoraphobia is fear of being in places or situations from which it may be difficult or embarrassing to get away, or a fear that help might be unavailable in the event of having a panic attack.

People with agoraphobia most commonly experience fear in a cluster of situations: in supermarkets and department stores, crowded places of all kinds, confined spaces, public transport, elevators, highways, etc.

People experiencing agoraphobia may find comfort in the company of a safe person or object. This may be a spouse, friend, pet or medicine carried with them.

The onset of agoraphobia is common between the ages of 15 and 20, and is often associated with Panic Disorder or Social Anxiety Disorder.

Panic Disorder (With or Without Agoraphobia)

People with this disorder experience panic attacks in situations where most people would not be afraid such as at home, walking in the park or going to a movie. These attacks occur “out of the blue”, come on rapidly (over a few minutes) and go away slowly. Usually they last about 10-15 minutes.

The attacks are accompanied by all of the unpleasant physical symptoms of anxiety, plus a fear that the attack may lead to a total loss of control or death.

It is because of this that some people start to experience a fear of going to places where panic attacks may occur and of being in places where help is not at hand. In addition to panic attacks and Agoraphobia symptoms, people with Panic Disorder also worry about having another panic attack.

Phobias

Everyone has some mild irrational fears, but phobias are intense fears about particular objects or situations which interfere with our lives or harm us. These might include fear of heights, water, dogs, closed spaces snakes or spiders.

Someone with a phobia is fine when the feared object is not present. However, when faced with the feared object or situation, the person can become highly fearful and even experience a panic attack.

People affected by phobias can go to great lengths to avoid situations which would force them to confront the object or situation which they fear.

Social Anxiety Disorder

People with Social Anxiety Disorder worry that others will judge everything they do in a negative way and they feel easily embarrassed in most social situations. They believe they may be considered to be flawed or worthless if any sign of poor performance is detected.

They cope by either trying to do everything perfectly, limiting what they are doing in front of others (especially eating, drinking, speaking or writing) or withdrawing gradually from contact with others. They will often experience panic symptoms in social situations and will avoid many situations where they feel observed by others (such as in shops, the cinema, public speaking and social events).

Anxiety Disorders are among the most common of the mental illnesses. About 5% of people can be expected to experience an Anxiety Disorder during their adolescent years.

For more information on some Anxiety Disorders, check out:

www.teenmentalhealth.org/product/tmh-speaks-social-anxiety/

www.teenmentalhealth.org/product/tmh-speaks-panic-disorder/

What Causes Anxiety Disorders?

The causes of each disorder may vary, and it is not always easy to determine the causes in every case. All Anxiety Disorders are associated with abnormalities in the brain's emotional response mechanisms that are involved in the creation and expression of the stress response.

Personality

People with certain personality characteristics may be more prone to Anxiety Disorders. Those who are easily upset, are very sensitive, emotional or avoidant of others may be more likely to develop Anxiety Disorders.

Learned Response

Some people who are exposed to situations, people or objects that are upsetting or anxiety-producing may develop an anxiety response when faced with the same situation, person or object again, or become anxious when thinking about the situation, person or object. This is not likely to lead to an Anxiety Disorder.

Heredity

The tendency to develop Anxiety Disorders has a genetic basis and runs in families.

Avoidance

This is a common behavioural response in people who have an Anxiety Disorder. Unfortunately, avoidance can make the symptoms of anxiety worse in the long run.

How Can Anxiety Disorders be Treated?

If they are not effectively treated, Anxiety Disorders may interfere significantly with a person's thinking and behaviour. This can cause considerable suffering and distress. Some Anxiety Disorders may precede Depression or Substance Abuse and in such cases treatment may help to prevent these problems.

Many professionals such as family doctors, psychologists, social workers, counsellors or psychiatrists can help people deal with Anxiety Disorders.

Treatment will often include education and specific types of psychotherapy (such as Cognitive Behavioural Therapy) to help the person understand their thoughts, emotions and behaviour. People develop new ways of thinking about their anxiety and how to deal more effectively with feelings of anxiety.

Medication is sometimes used to help the person control their high anxiety levels, panic attacks or Depression.

The benzodiazepines (such as diazepam) are used for the temporary relief of anxiety, but care has to be taken with their use as these medications may occasionally cause difficulties in some people.

Antidepressants play an important role in the treatment of some Anxiety Disorders, as well as associated or underlying Depression. Contrary to the belief of some, antidepressants are not addictive.

MODULE 3C

Activity #4 Activity Sheet

Group #1: Understanding Anxiety Disorders (Reporting Page)

What are Anxiety Disorders?

How common are Anxiety Disorders?

Describe some of the symptoms of Anxiety Disorders:

List and briefly explain some of the main types of Anxiety Disorders:

What type of treatment is available for people experiencing Anxiety Disorders?

What other kinds of support can help people with Anxiety Disorders recover?

Group #2: Attention Deficit Hyperactivity Disorder (ADHD) (Fact Sheet)

What is Attention Deficit Hyperactivity Disorder (ADHD)?

Attention Deficit Hyperactivity Disorder is the most commonly diagnosed behavioural disorder of childhood.

ADHD affects an estimated 1-2 % of children and young people in the UK. Boys are two to three times more likely to develop ADHD. Although ADHD is usually associated with children and teens, the disorder can persist into adulthood. People with ADHD are easily distracted by sights, sounds, and other features of their environment. They cannot concentrate for long periods of time, are restless and impulsive, or have a tendency to daydream and be slow to complete tasks.

Symptoms

The three predominant symptoms of ADHD are 1) difficulty regulating activity level (hyperactivity), 2) difficulty attending to sustained tasks (inattention), and 3) impulsivity.

Common symptoms include the following:

- Brief sustained attention span
- Increased activity - always on the go
- Impulsive - does not stop to think
- Social and relationship problems
- Takes undue risks
- Sleep problems
- Normal or high intelligence but under-performing at school

All must occur with greater frequency and intensity than in other people of the same age and must lead to functional impairment as a result of the symptoms in order to be considered ADHD.

What Causes ADHD?

While no one really knows what causes ADHD, it is generally agreed by the medical and scientific community that ADHD is due to problems in the brain's control of systems that regulate concentration, motivation, planning and attention.

Much of today's research suggests that genetics play a major role in ADHD. The possibility of a genetic cause of ADHD is supported by the fact that ADHD runs in families. About 70% of children with ADHD have a first-degree relative with ADHD. Approximately half of parents who have been diagnosed with ADHD themselves will have a child with ADHD.

However, not every person with ADHD can be explained by genetics; there are other causes of ADHD.

MODULE 3C

Activity #4 Handout

Researchers have suggested that some of the following could also be responsible for ADHD symptoms:

- Exposure to toxins (such as lead)
- Injuries to the brain (such as a concussion)
- A traumatic birth process

Many people with ADHD will also have a specific learning difficulty, such as problems with spelling, mathematics, etc. Some studies suggest that about 30% of adolescents with ADHD may have a learning difficulty.

Myths, Misunderstandings and Facts

According to the National Institute of Mental Health, ADHD is not caused by:

- Too much TV
- Sugar
- Caffeine
- Food colourings
- Poor home life
- Poor schools
- Food allergies

How can ADHD be treated?

A variety of medications and behavioural interventions are used to treat ADHD. The most effective treatments are medications. The most widely used medications are stimulants such as methylphenidate. These medications are safe when used as prescribed by qualified physicians. Some common side effects are decreased appetite and insomnia. These side effects generally occur early in treatment and often decrease over time. Some studies have shown that the stimulants used to treat ADHD slow growth rate, but ultimate height is not affected. Medication treatment reduces risk of substance abuse and traffic accidents as well.

Other interventions used to help treat ADHD include several forms of psychotherapy such as Cognitive Behavioural Therapy, social skills training, support groups, and parent and educator skills training. A combination of medication and psychotherapy may be more effective than medication treatment alone in improving social skills, parent-child relations, reading achievement and aggressive symptoms.

For more information on ADHD, check out:

www.teenmentalhealth.org/product/tmh-speaks-adhd/

Group #2: Understanding Attention Deficit Hyperactivity Disorder (ADHD) (Reporting Page)

What is ADHD?

How common is ADHD?

Describe some of the symptoms of ADHD:

What type of treatment is available for people experiencing ADHD?

What other kinds of support can help people with ADHD recover?

MODULE 3C

Activity #4 Handout

Group #3: Bipolar Mood Disorder (Fact Sheet)

What is Bipolar Mood Disorder?

Bipolar Mood Disorder is the new name for what was once called manic depressive illness. The new name is used as it better describes the extreme mood swings - from Depression and sadness to elation and irritability that people with this illness experience.

People with Bipolar Mood Disorder experience recurrent episodes of depressed and elated or irritable moods. Both can be mild to severe.

What are the symptoms of Bipolar Mood Disorder?

Mania - Common symptoms include varying degrees of the following:

- **Elevated mood** – The person feels extremely high, happy and full of energy. The experience is often described as feeling on top of the world and being invincible.
- **Increased energy and overactivity**
- **Reduced need for sleep**
- **Irritability** – The person may easily and frequently get angry and irritable with people who disagree or dismiss their sometimes unrealistic plans or ideas.
- **Rapid thinking and speech** – Thoughts are more rapid than usual. This can lead to the person speaking quickly and jumping from subject to subject.
- **Lack of inhibitions** – This can be the result of the person's reduced ability to foresee the consequences of their actions. For example, spending large amounts of money buying things they don't really need.
- **Grandiose plans and beliefs** – It is common for people experiencing Mania to believe that they are unusually talented or gifted or are kings, movie stars or political leaders. It is common for religious beliefs to intensify or for people with this illness to believe they are an important religious figure.
- **Lack of insight** – A person experiencing Mania may understand that other people see their ideas and actions as inappropriate, reckless or irrational. However, they are unlikely to recognise the behaviour as inappropriate themselves.
- **Psychosis** – Some people with Mania or Depression experience psychotic symptoms such as hallucinations and delusions.

Depression - Common symptoms include varying degrees of the following:

- **Lowered mood** – Many people with Bipolar Mood Disorder experience depressive episodes. These are similar in nature to those experienced by people who have Depression.
- **Withdrawal** – The person loses interest and pleasure in activities they previously enjoyed. They may withdraw and stop seeing friends, avoid social activities and cease simple tasks such as shopping and showering.

MODULE 3C

Activity #4 Handout

- **Loss of appetite or weight** – They may become overwhelmed by Depression, lose their appetite, lose weight, become unable to concentrate, and may experience feelings of guilt.
- **Feelings of hopelessness** – Some attempt suicide because they believe life has become meaningless or they feel too guilty to go on.
- **Delusions** – Others develop false beliefs (delusions) of persecution or guilt, or think that they are evil.

For more information on Depression and its treatment, please see the information sheet called “What is Depression?”

Normal Moods

Most people who have episodes of Mania and Depression experience normal moods in between. They are able to live productive lives, manage household and business commitments and hold down a job.

Everyone experiences mood swings from time to time. This is not Bipolar Mood Disorder. It is when these moods become extreme and lead to a failure to cope with life that medical attention is necessary.

What Causes Bipolar Mood Disorder?

Bipolar Mood Disorder affects approximately 1-2% of the population across the United Kingdom. Everyone has an equal chance of developing the disorder. It usually appears when people are in their twenties, but often begins in the teen years.

Genetic Factors

Studies on close relations, identical twins and adopted children whose natural parents have Bipolar Mood Disorder strongly suggest that the illness may be genetically transmitted, and that children of parents with Bipolar Mood Disorder have a greater risk of developing the disorder.

Stress

Stress may play a role in triggering symptoms, but is not a cause of the illness. Often the illness itself may cause the stressful event (such as divorce or a failed business), which may then be blamed for causing the illness. Drugs or other physical stressors (such as jet lag) may bring on an episode.

Seasons

Mania is more common in the spring, and Depression in the early winter. The reason for this is not clear, but it is thought to be associated with the light/dark cycle, and the amount of total daily sunshine.

How Can Bipolar Disorder be Treated?

- Effective treatments are available for depressive and manic episodes of Bipolar Mood Disorder. Medications called thymoleptics (such as lithium) are an essential treatment for the entire course of the illness.
- Antidepressant medications and some psychological treatments are effective for the depressive phase of the illness. Bright light therapy may also help.
- Medications used to treat people with Bipolar Mood Disorder are not addictive.

MODULE 3C

Activity #4 Handout

- Several different medications may be used during acute or severe attacks of Mania. Some are specifically used to calm the person's manic behaviour; others are used to help stabilise the person's mood or treat psychiatric symptoms. Medications such as lithium are also used as preventive measures as they help to control mood swings and reduce the frequency and severity of both depressive and manic phases.
- It may be necessary to admit a person with severe Depression or Mania to a hospital for some time.
- It can often be difficult to persuade someone that they need treatment when they are in a manic phase.
- Psychotherapy and counselling are used with medication to help the person understand the illness and better manage its effects on their life.
- With access to appropriate treatment and support, most people with Bipolar Mood Disorder lead full and productive lives.

For more information on Bipolar Mood Disorder, check out:

www.teenmentalhealth.org/product/tmh-speaks-bipolar-disorder/

Group #3: Understanding Bipolar Mood Disorder (Reporting Page)

What is Bipolar Mood Disorder?

How common is Bipolar Mood Disorder?

Describe some of the symptoms of Bipolar Mood Disorder:

What combination of factors is believed to cause Bipolar Mood Disorder?

What type of treatment is available for people experiencing Bipolar Mood Disorder?

What other kinds of support can help a person with Bipolar Mood Disorder recover?

MODULE 3C

Activity #4 Handout

Group #4: Depression (Fact Sheet)

What is Depression?

The word “Depression” is often used to describe the feelings of sadness or unhappiness which all of us experience at some point in our lives. It is also a term used to describe a type of mental illness called Clinical Depression or just Depression.

Because Depression is so common, it is important to understand the difference between unhappiness or sadness in daily life and the symptoms of Clinical Depression.

When faced with significantly high stress (such as the loss of a loved one, relationship breakdown or great disappointment), most people will feel unhappy or sad. These are emotional reactions which are appropriate to the situation and will usually last only a limited time. These reactions are not a Depression, but are a part of everyday life.

The term Depression describes not just one illness, but a group of illnesses characterised by excessive or long-term depressed mood which negatively affects the person’s life. Depression is often accompanied by feelings of anxiety. Whatever the symptoms and causes of Depression, there are many therapeutic interventions which are effective.

To help differentiate the symptom of “Depression” from the mental disorder “Depression” we capitalise the “D” when we mean the illness.

“Baby Blues” and Postpartum Depression

The so-called “baby blues” affect about half of all new mothers. They feel mildly depressed, anxious, tense or unwell, and may have difficulty sleeping even though they feel tired most of the time. These feelings may last only hours or a few days, then disappear. Professional help is not usually needed. This is not Depression.

However, in up to ten percent of mothers this feeling of sadness develops into a serious disorder called Postpartum Depression. Mothers with this illness find it increasingly difficult to cope with the demands of everyday life.

They can experience anxiety, fear, despondency and severe sadness. Some mothers may have panic attacks or become tense and irritable. There may be a change in appetite and sleep patterns. Because of these symptoms they may have difficulties in their daily lives, including trouble in caring for their child.

A severe, but rare form of Postpartum Depression is called Puerperal Psychosis. The mother is unable to cope with her everyday life and is disturbed in her thinking and behaviour. Professional help is needed for both Postpartum Depression and Puerperal Psychosis. This form of Depression may be genetic and can run in families.

Major Depressive Disorder

This is the most common form of Depression. It can come on without apparent cause, although in some cases a severely distressing event might trigger the condition.

The cause is not well understood but is believed to be associated with changes in brain circuits that control mood. Genetic predisposition is common.

A Depression can develop in people who have coped well with life, who are good at their work, and who are happy in family and social relationships.

For no apparent reason, they can become low-spirited, lose their enjoyment of life and suffer from disturbed sleep patterns. People experiencing Depression have severe negative emotions, negative thoughts and behavioural and physical symptoms.

Sometimes feelings of hopelessness and despair can lead to thoughts of suicide. Suicide is a tragic outcome of Depression in some people.

The most serious form of this type of Depression is called Psychotic Depression. During this illness, the person loses touch with reality, may stop eating and drinking and may hear voices (called hallucinations) saying they are wicked, or worthless or deserve to be punished.

Others develop false beliefs (delusions) that they have committed bad deeds in the past and deserve to be punished, or falsely believe that they have a terminal illness such as cancer (despite there being no medical evidence).

Depression is a serious illness which presents risks to the person's life and well-being. Professional assessment and treatment is always necessary and hospitalisation may be required in severe cases.

Bipolar Mood Disorder

A person with Bipolar Mood Disorder experiences Depression with periods of Mania which involve extreme happiness, overactivity, rapid speech, a lack of inhibition and in more serious instances, psychotic symptoms including hearing voices and delusions of grandeur.

Sometimes only periods of Mania occur without depressive episodes, but this is rare. More information about this mood disorder is found in the section called "What is Bipolar Mood Disorder?"

What Causes Depression?

Depression is caused by a combination of environmental and genetic factors. Depression "runs" in families but most people who have a family member with Depression do not develop the illness.

Depression may also begin after personal tragedies or disasters. It is more common at certain stages of life (such as at childbirth). It may also occur with some physical illnesses. However, Depression often causes life stresses which may be incorrectly considered to be causes of Depression.

How Can Depression be Treated?

People experiencing Depression should contact their doctor or community health centre. Treatments for Depression can help the person return to more normal feelings and to enjoy life. The approach depends on each person's symptoms and circumstances, but will generally take one or more of the following forms:

- Psychological interventions that can help individuals understand their thoughts, behaviours and interpersonal relationships. These treatments often take 8-12 weeks to achieve positive effects.

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Activity #4 Handout

- Antidepressant medications relieve depressed feelings, restore normal sleep patterns and appetite, and reduce anxiety. Antidepressant medications are not addictive. In young people, they can take 8-10 weeks to achieve their positive effects.
- General supportive counselling assists people in sorting out practical problems and conflicts, and helps them understand how to cope with their Depression.
- Lifestyle changes (such as vigorous physical exercise) may help people who suffer from Depression.
- For some severe forms of Depression, electroconvulsive therapy (ECT) is a safe and effective treatment. It may be lifesaving for people who are psychotic, at high risk of suicide, or who, because of the severity of their illness, have stopped eating or drinking and may die as a result.

For more information on Depression, check out:

www.teenmentalhealth.org/product/tmh-speaks-Depression/

Group #4: Understanding Depression (Reporting Page)

What is Depression?

How common is Depression?

Describe some of the symptoms of Depression:

List and briefly describe some of the main types of Depression:

What type of treatment is available for people experiencing Depression?

What other kinds of support can help a person with Depression recover?

MODULE 3C

Activity #4 Handout

Group #5: Eating Disorders (Fact Sheet)

What are Eating Disorders?

Anorexia Nervosa (AN) and Bulimia Nervosa (BN) are the two most common serious eating disorders. Each illness involves a preoccupation with control over body weight, eating and food.

- People with AN are determined to control the amounts of food they eat
- People with BN tend to feel out of control with food

Anorexia Nervosa may affect up to one fifteen year old girl in every one hundred and fifty, and one fifteen year old boy in every thousand (Royal College of Psychiatrists, 2019).

Bulimia Nervosa may affect up to four in every one hundred women (Royal College of Psychiatrists, 2019). More females develop Bulimia Nervosa.

While these rates show that few people meet the criteria for eating disorders, it is far more common for people to have unrealistic attitudes about body size and shape. These attitudes may contribute to inappropriate eating or dieting practices, such as fad dieting, which is not the same as having an eating disorder.

Both illnesses can be treated and it is important for the person to seek advice about treatment for either condition as early as possible.

What are the Symptoms of Anorexia Nervosa (AN)?

Anorexia Nervosa is characterised by:

- A loss of at least 15% of body weight resulting from refusal to eat enough food
- Refusal to maintain minimally normal body weight
- An intense fear of becoming 'fat' even though the person is underweight
- Cessation of menstrual periods in girls
- Misperception of body image, so that people see themselves as fat when they're really very thin
- A preoccupation with the preparation of food
- Unusual rituals and activities pertaining to food, such as making lists of 'good' and 'bad' food and hiding food.

Anorexia Nervosa may begin with a weight loss resulting from dieting. Many people diet but only a few develop AN, so clearly dieting does not cause AN. It is not known why some people go on to develop AN while others do not. As weight decreases, the person's ability to appropriately judge their body size and make proper decisions about their eating also decreases.

What are the Symptoms of Bulimia Nervosa (BN)?

Bulimia Nervosa is characterised by:

- Eating binges involve consumption of large amounts of calorie-rich food, during which the person feels a loss of personal control and following which the person feels self disgust
- Attempts to compensate for binges and to avoid weight gain by self-induced vomiting, over-exercising and/or abuse of laxatives and diuretics
- Strong concerns about body shape and weight

A person with BN is usually average or slightly above average weight for height, so it is often less recognisable than a person with AN.

BN often starts with rigid weight reduction dieting in an attempt to reach 'thinness'. But again, many people diet while only a few develop BN.

Vomiting after a binge seems to bring a sense of relief, but this is temporary and soon turns to distress and guilt. Some people use laxatives, but these do not cause weight loss. Instead they make it difficult for your body to be healthy by causing dehydration and poor absorption of vitamins and minerals the body needs.

The person can make many efforts to break from the pattern, but the binge/purge/exercise cycle, and the feelings associated with it, may have become compulsive and uncontrollable.

What Causes Anorexia Nervosa and Bulimia Nervosa?

The causes of AN and BN remain unclear. Biological and social factors may be involved. While there are many hypotheses about various factors involved in AN, there is no good scientific evidence which shows causality for one particular pathway.

What are the Effects of Anorexia Nervosa and Bulimia Nervosa?

- **Physical effects** – The physical effects can be serious, but are often reversible if the illnesses are tackled early. If left untreated, AN and BN can be life-threatening. Responding to early warning signs and obtaining early treatment is essential. AN can lead to death from the physical effects of starvation.
- **Both illnesses, when severe, can cause:**
 - Harm to kidneys
 - Urinary tract infections and damage to the colon
 - Dehydration, constipation and diarrhoea
 - Seizures, muscle spasms or cramps
 - Chronic indigestion
 - Loss of menstruation or irregular periods
 - Heart palpitations

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Activity #4 Handout

- **Many of the effects of AN are related to malnutrition, including:**
 - Absence of menstrual periods
 - Severe sensitivity to cold
 - Growth of down-like hair all over the body
 - Inability to think rationally and to concentrate
- **Severe BN is likely to cause:**
 - Erosion of dental enamel from vomiting
 - Swollen salivary glands
 - The possibility of a ruptured stomach or oesophagus
 - Chronic sore throat
- **Emotional and Psychological Effects** – these are likely to include:
 - Difficulty with activities which involve food
 - Loneliness, due to self-imposed isolation and a reluctance to develop personal relationships
 - Deceptive behaviours related to food
 - Fear of the disapproval of others if the illness becomes known, mixed with the hope that family and friends might intervene and offer help
 - Mood swings, changes in personality, emotional outbursts or depressive feelings

How Can Eating Disorders Be Treated?

Changes in eating behaviour may be caused by several illnesses other than AN or BN, so a thorough medical examination by a medical doctor is the first step.

Once the illness has been diagnosed, a range of health providers can be involved in treatment, because the illness affects people both physically and mentally. Professionals involved in treatment may include psychiatrists, psychologists, physicians, dietitians, social workers, occupational therapists and nurses.

Outpatient treatment and attendance in special programs are the preferred method of treatment for people with AN. Hospitalisation may be necessary for those who are severely malnourished.

There is no known medication for treating AN. Many people with BN get better taking an antidepressant medicine, even if they do not have Depression.

Dietary education assists with retraining in healthy eating habits.

Counselling and specific therapies such as Cognitive Behavioural Therapy (CBT) are used to help change unhealthy thoughts about eating. The ongoing support of family and friends is essential.

In teenagers, a type of family therapy called Multidimensional Family Therapy is often used.

Group #5: Understanding Eating Disorders (Reporting Page)

What are eating disorders?

How common are eating disorders?

Describe some of the symptoms of Anorexia Nervosa (AN) and Bulimia Nervosa (BN):

What are some physical, emotional and psychological effects of AN and BN?

What type of treatments are available for people experiencing AN and BN?

What other kinds of support can help people with eating disorders recover?

MODULE 3C

Activity #4 Handout

Group #6: Schizophrenia (Fact Sheet)

What is Schizophrenia?

Schizophrenia is a mental illness which affects about one person in every hundred. Schizophrenia is one of a group of illnesses called Psychotic Disorders. It interferes with a person's mental functioning and behaviour, and in the long term may cause changes to their personality.

The first onset of Schizophrenia is usually in adolescence or early adulthood. Some people may experience only one or more brief episodes of psychosis in their lives, and may not develop the illness called Schizophrenia. For others, it may remain a recurrent or life-long condition.

The onset of the illness may occasionally be rapid, with acute symptoms developing over months. More commonly, it may be slow and develop over years.

Schizophrenia is characterised by two different sets of symptoms: positive and negative. Positive symptoms include delusions (fixed, false beliefs) and hallucinations (perceptual disturbances such as hearing things that are not there).

Negative symptoms refer to things taken away by the illness, so that a person has less energy, less pleasure and interest in normal life activities, spending less time with friends and being less able to think clearly. These symptoms tend to begin gradually and become more pronounced over time.

What are the symptoms of Schizophrenia?

- **Positive symptoms of Schizophrenia include:**
 - **Delusions** – false beliefs of persecution, guilt or grandeur, or being under outside control. These beliefs will not change regardless of the evidence against them. People with Schizophrenia may describe outside plots against them or think they have special powers or gifts. Sometimes they withdraw from people or hide to avoid imagined persecution.
 - **Hallucinations** – most commonly involving hearing voices. Other less common experiences can include seeing, feeling, tasting or smelling things (which to the person are real but which are not actually there).
 - **Thought disorder** – where the speech may be difficult to follow, for example, jumping from one subject to another with no logical connection. Thoughts and speech may be jumbled and disjointed. The person may think someone is interfering with their mind.
- **Other symptoms of Schizophrenia include:**
 - **Loss of drive** – when the ability to engage in everyday activities (such as washing and cooking) is lost. This lack of drive, initiative or motivation is part of the illness and is not laziness.
 - **Blunted expression of emotions** – where the ability to express emotion is reduced and is often accompanied by a lack of response or an inappropriate response to external events such as feeling happy on a sad occasion.
 - **Social withdrawal** – this may be caused by a number of factors including the fear that someone is going to harm them, or a fear of interacting with others because of a loss of social skills.

- **Lack of insight or awareness of other conditions** – because some experiences such as delusions or hallucinations seem so real, it is common for people with Schizophrenia to be unaware they are ill. For this and other reasons, such as medication side-effects, they may refuse to accept treatment which could be essential for their well being.
- **Thinking difficulties** – a person's concentration, memory and ability to plan and organise may be affected, making it more difficult to reason, communicate and complete daily tasks.

What causes Schizophrenia?

No single cause has been identified, but several factors are believed to contribute to the onset of Schizophrenia:

- **Genetic factors** – A predisposition to Schizophrenia can run in families and has a genetic cause. In the general population, about one percent of people develop it over their lifetime. Some people develop the illness without having it in their family.
- **Family relationships** – No evidence has been found to support the suggestion that family relationships cause the illness. However, some people with Schizophrenia are sensitive to family tensions which, for them, may be associated with relapses.
- **Environment** – Stress does not cause Schizophrenia. People with Schizophrenia often become anxious, irritable and unable to concentrate before any positive symptoms are evident. This can cause relationships to deteriorate, possibly leading to divorce or unemployment. Often these factors are blamed for the onset of the illness when in fact the illness itself has caused the crisis. There is some evidence that environmental factors that damage brain development (such as a viral illness in utero) may lead to Schizophrenia later in life.
- **Drug use** – The use of some drugs, such as cannabis (marijuana), LSD, crack and crystal meth may cause a relapse in Schizophrenia. Some people with a particular genetic type may be at higher risk for Schizophrenia if they use marijuana often. Occasionally, severe drug use may lead to Schizophrenia.

Myths, Misunderstandings and Facts

Myths, misunderstandings, negative stereotypes and attitudes surround the issue of mental illness in general - and in particular, Schizophrenia. They result in stigma, discrimination and isolation.

Do people with Schizophrenia have a split personality?

No. Schizophrenia refers to the change in the person's mental function where the thoughts and perceptions become disordered.

Are people with Schizophrenia dangerous?

Not usually. People with Schizophrenia are generally not dangerous when receiving appropriate treatment. However, a minority of people with the illness may become aggressive when experiencing an untreated acute episode, or if they are taking illicit drugs. This is usually expressed to family and friends - rarely to strangers.

MODULE 3C

Activity #4 Handout

Is Schizophrenia a life-long mental disorder?

Like many mental illnesses, Schizophrenia is usually lifelong. However most people, with professional help and social support, learn to manage their symptoms and have a reasonable quality of life. About 20-30 percent of people with Schizophrenia have only a few psychotic episodes in their lives.

How can Schizophrenia be treated?

The most effective treatment for Schizophrenia involves medication. In addition, psychological counselling and help with managing its impact on everyday life is often needed.

The sooner that Schizophrenia is treated, the better the long-term prognosis or outcome. The opposite is also true, the longer Schizophrenia is left untreated, and the more psychotic breaks are experienced by someone with the illness, the lower the level of eventual recovery. Early intervention is key to helping people recover.

The development of antipsychotic medications has revolutionised the treatment of Schizophrenia. Now, most people can be treated and remain in the community instead of in hospital.

Antipsychotic medications work by correcting the brain chemistry associated with the illness. New medications are emerging which may promote a more complete recovery with fewer side effects than the older versions.

Schizophrenia is an illness like many physical illnesses. Just as insulin is a lifeline for people with diabetes, antipsychotic medications can be a lifeline for a person with Schizophrenia. Just as with diabetes, some people will need to take medication indefinitely to prevent a relapse and keep symptoms under control.

Although there is no known cure for Schizophrenia, regular contact with a doctor or psychiatrist and other mental health professionals such as nurses, occupational therapists and psychologists can help a person with Schizophrenia recover and get on with their lives. Informal supports such as self-help and social support are also very important to recovery. Meaningful activity, employment assistance and adequate housing and income are all essential to keeping people healthy.

Sometimes specific therapies directed toward symptoms (such as delusions) may also be useful.

Counselling and social support can help people with Schizophrenia overcome problems with finances, housing, work, socialising and interpersonal relationships.

With effective treatment and support, most people with Schizophrenia can lead fulfilling and productive lives.

Group #6: Understanding Schizophrenia (Reporting Page)

What is Schizophrenia?

How common is Schizophrenia?

Describe some of the symptoms of Schizophrenia:

List and briefly explain some of the factors that may contribute to the onset of Schizophrenia:

What type of treatment is available for people with Schizophrenia?

What other kinds of support can help people with Schizophrenia recover?

MODULE 3C

Activity #4 Handout

Group #7: Obsessive Compulsive Disorder (OCD) (Fact Sheet)

What is OCD?

Obsessive Compulsive Disorder (OCD) is a disturbance of specific brain circuits that leads to two different but related symptoms called “obsessions” and “compulsions”. In OCD a person experiences persistent, recurrent, intrusive and unwanted thoughts, ideas or fears (obsessions) and repeated, ritualised behaviours (compulsions) that are done to try and stop the worry and anxiety brought on by the obsessions.

Obsessions are frequent, persistent, recurring thoughts that the person wants to get rid of but can't. These thoughts are so pervasive that they can take over a person's life, constantly intruding into and disrupting every-day activities. The person does not really believe that the thoughts are true but has great difficulty in stopping them. These recurring thoughts cause significant worry and anxiety and may lead to compulsions. Obsessive thoughts commonly involve contamination (for example “there are germs on my hands and I will catch a horrible disease”) or harm (“my brother will die”).

Compulsions are the persistent repetitive rituals that a person does to try and obtain relief from the obsession. Common compulsions include: ordering, washing, counting, tapping, and repeating. These compulsions can take many hours in a day to perform and a person experiencing them frequently feels a strong urge to do them even though they do not want to.

Although OCD can begin at many different points in a person's life, most commonly it starts before age 20.

Everybody experiences occasional repetitive thoughts, phrases, worries (such as “did I lock the door?”) or even musical snippets (called “ear worms”). These are normal and are not obsessions. Everyone also experiences occasional repetitive behaviours such as checking to make sure the door is locked or the stove is turned off (even though they know it is). These are not compulsions.

What causes OCD?

We think that a combination of different things, including genetics and environmental factors lead to OCD. One recently discovered environmental factor is a bacterial infection that leads to an immune reaction involving the brain circuits that are involved in OCD.

How can OCD be treated?

A number of treatments are available for OCD. These include both biological and psychological treatments. Selective Serotonin Reuptake Inhibitor (SSRI) medicines and Cognitive Behavioural Therapy (CBT) are prescribed together to help treat the person that has OCD. Sometimes family therapy is provided because having OCD can affect how a person's family is doing.

A person with OCD can also do a number of other things to try and help manage their condition. These include exercise and activities that require intensive concentration. While these can be somewhat helpful, they do not take the place of SSRI and CBT treatments.

Group #7: Understanding Obsessive Compulsive Disorder (OCD) (Reporting Page)

What is OCD?

How common is OCD?

Describe some of the symptoms of OCD:

What combination of factors is thought to cause OCD?

What type of treatment is available for people with OCD?

What other kinds of support can help people with OCD recover?

MODULE 3C

Activity #4 Handout

Group #8: Post-Traumatic Stress Disorder (PTSD) (Fact Sheet)

What is Post-Traumatic Stress Disorder (PTSD)?

PTSD is a disturbance of the normal stress response to a severe and often life-threatening event. This response persists well beyond the expected time and causes significant problems in daily life. Sometimes the PTSD can be so intense that a person has great difficulties at home, work or school and may require a brief period of time in hospital to help recover.

Everyone experiences substantial symptoms of emotional distress when faced with a severe and sometimes life-threatening stressor (such as: being in an car accident, being sexually assaulted, witnessing a murder or an event where people die, experiencing an earthquake, etc.). These symptoms include: anxiety, fear, trouble sleeping, bad dreams, recurring thoughts or images of the event, irritability, etc. These symptoms are normal; everyone who lives through such an experience has them. This is not PTSD. It is called an Acute Stress Reaction (ASR) and it gradually goes away over a few months if the person is in a safe environment and receives support from their family and friends.

PTSD is the continuation of the ASR for many months or even years, and also includes other symptoms such as: re-experiencing the event, persistent high emotional intensity, feelings of “being on edge”, nightmares, depressed mood and even suicidal thoughts. Fortunately, the majority of people who experience severe and sometimes life-threatening events do not develop PTSD – in fact, most don’t.

Recently it has become popular to use the word “trauma” to describe negative but common life events such as failing an exam, going through a difficult breakup, or leaving home to go to college. The use of the word “trauma” has also been used to indicate feeling hurt, angry or upset if someone challenges a person’s political, religious or other beliefs. These are not trauma. They may lead to negative emotions but do not cause PTSD. We need to be clear in our language.

What causes PTSD?

Unlike all other mental illnesses, PTSD is ALWAYS caused by a terrible event that occurs in a person’s life. However, most people who experience such events do not develop PTSD. Recently scientists have discovered that genes also play an important role in determining who will and who will not develop PTSD.

How can PTSD be treated?

PTSD is usually diagnosed if severe symptoms that negatively impact daily life have persisted for months after the event. A number of psychological treatments can be prescribed and can be helpful for many people. Some people with PTSD will also benefit from taking one of a number of different medications. We also know that some things we do for people after they experience a traumatic event can increase the risk that they will get PTSD. These things include forcing people to talk about the event after they have experienced it in the mistaken belief that forcing them to talk about it will make it better for them.

Support from family members, friends and the wider community are helpful for people who have PTSD. As with all mental disorders, taking care of your physical health by getting enough exercise, eating healthy food, limiting use of alcohol, avoiding drugs and being with people who care for you can provide additional benefit to prescribed treatments.

Group #8: Understanding Post-Traumatic Stress Disorder (PTSD) (Reporting Page)

What is PTSD?

How common is PTSD?

Describe some of the symptoms of PTSD:

What combination of factors is thought to cause PTSD?

What type of treatment is available for people with PTSD?

What other kinds of support can help people with PTSD recover?

MODULE 3C

Activity #5

Sharing the Pieces (20 minutes)

Purpose:

- In this activity, the group reporters will share their new knowledge about their mental illness with others in the class. In this way, all pupils will gain an increased understanding of the mental illnesses covered in the module.

How-to:

- 1) Have the reporter from each group present their Reporting Page to the class.
- 2) Guide discussions and provide further information as indicated.

Parents and Mental Illness

Some of your pupils will have a parent or other family member (including a sibling) who has a mental illness. Information about how to better deal with the experience of having a parent or sibling with a mental illness is now available at www.teenmentalhealth.org/product/family-pack/. Please bring the “Family Pack” to the attention of your pupils by showing the class where they can find it.

Experiences of Mental Illness and the Importance of Family Communication

Overview

In this module pupils will hear directly from other young people about their personal experiences with mental illness. In their own words, a number of young people describe their symptoms, the difficulties they went through as a result of their illness, and how the illness affected their lives at school, within their families, and in their friendships.

Pupils will work together in small groups to explore the impact of mental illnesses on the lives of the young people in the video. Pupils will also be introduced to two resources: “How Do I Teen My Parent?” and “How Do I Parent My Teen?”

Learning Objectives

In this lesson pupils will learn to:

- Understand on a personal level the way mental illnesses can impact a person’s life
- Appreciate the importance of getting help and proper treatment for a mental illness
- Stress the importance of positive communications between parents and teens

Major Concepts Addressed

- Mental illnesses are diseases that affect many aspects of a person’s life.
- While they are usually lifelong, mental illnesses are often episodic and most people can function well in everyday life with effective treatment.
- Young people can better understand and communicate with parents and vice-versa.

Teacher Background and Preparation

Teachers should preview Module 4 materials and each of the six video stories. Reviewing the videos in advance will help you become familiar with the content so that you can then help pupils understand how a mental illness has affected the lives of these young people.

The materials are located on:
www.actionforchildren.org.uk/TheGuide
The password is: **GuideCymru**

Activities

- Activity 1: Video Discussion Sheet (30 min.)
- Activity 2: Teens and Parents (15 min.)

MODULE 4

Preparation

In Advance

- Decide whether you will show the videos to the class as a whole (and if so which videos you will show) or if you want smaller groups to view the videos through the web-based format
- Set up computer work stations
- Photocopy Activity 1 Video discussion sheet (1 copy of each per student)
- Locate the “How Do I Teen My Parent?” and “How do I Parent My Teen?” resources
- If you will be handing out the “How Do I Teen My Parent?” resource you will need to copy the PDF from the website (www.actionforchildren.org.uk/TheGuide)

Materials Required

- Web-based videos
- Handout: Activity 1 Video discussion sheet (this is also found in the Resource Appendix)
- Handout of “How Do I Teen My Parent?” (photocopy this from www.teenmentalhealth.org/product/teen-parent/ or direct pupils to it).

Key Message

The key message around suicide is this: suicidal thoughts mean that help is needed. Young people who are having suicidal thoughts need to reach out to a responsible adult who can get them the help that they need.

Useful Self-Education

Hot Idea or Hot Air: A Systematic Review of Evidence for Two Widely Marketed Youth Suicide Prevention Programs and Recommendations for Implementation.
www.ncbi.nlm.nih.gov/pubmed/26336375

How to Talk with Your Teen about Drugs - Communication Tips for Parents
www.canada.ca/en/health-canada/services/health-concerns/reports-publications/alcohol-drug-prevention/talk-your-teen-about-drugs-communication-tips-parents.html

Video Discussion Sheet (30 minutes)

Purpose:

- To explore the impact of mental illnesses on a young person.
- To look specifically at the experience of each character in the video through small group work.

How-to:

- 1) Inform the class that the videos they are about to see were created by young people who have experienced mental illness, and that they are about their experiences.

Before showing the videos, divide the class into groups and distribute the video activity sheet. Allocate each group one of the videos. Give the pupils a few minutes to read through the questions on the video discussion sheet. Explain that each group will focus specifically on one video.

- 2) Each group should play their video.
- 3) While in their small groups and after watching the video, have each group member complete their discussion sheet. After everyone has completed their own discussion sheet ask each group to talk about what they have written and to create a single group discussion sheet that one of the group members will then share with the class as a whole.
- 4) Bring the groups back together and ask a member of each group to summarise the discussion from each of the small groups for the class.

Suicidal Thoughts

Thoughts about suicide are common in adolescents. However, persistent or recurring thoughts about suicide signal that help is needed. It is useful to make sure your pupils understand that persistent or recurring thoughts about suicide is a signal to them that they need some extra help, and if they are experiencing this they should talk to the school counsellor.

Discussion of the video may raise the issue of youth suicide. While this discussion is appropriate within the broader context of mental illness, it is important that the discussion not become focused on suicide. Any discussion of suicide should:

- *avoid portraying suicide as romantic, heroic or tragic;*
- *avoid increasing knowledge about methods of suicide;*
- *emphasize the importance of seeking help and of everyone's responsibility to tell a trusted adult if a friend mentions thoughts of suicide, even if that person asks for it to be kept a secret.*

MODULE 4

Activity #1

The most important concept for pupils to grasp through the class discussion is that although the individuals in the videos had different mental illnesses and different experiences, there are some common themes and concerns for each person. Prompt pupils to think about the similarities among the individuals that arise in the videos.

- 5) Using the questions below, facilitate a discussion with the whole class:
 - a) What specific illnesses were mentioned in the videos?
 - b) What help or treatment did the people receive?
 - c) Did the people recover?
 - d) What did they find helpful to help them recover?
- 6) Conclude the activity by addressing any questions that pupils may have after watching the videos.

In Class Personal Contacts

Some schools have links with Organisations that have trained and professionally supported youth speakers that can provide personal experiences about their mental disorder. If such a resource is available in your community, this module provides an excellent opportunity to take advantage of that. If that is the case, you can substitute the speaker for the videos. Make sure that a reputable Organisation is sponsoring the speaker, the youth speaking has received training and that psychological supports are available to the speaker. Do not invite speakers who do not meet all three criteria. Speakers should not focus on self-harm, suicide or eating disorders.

MODULE 4

Activity #1 Discussion Sheet

Video Discussion Sheet

What are some of the symptoms of the illness that are described?

How did the illness affect the person?

Did the illness cause the person difficulty in their life? In what ways?

What kind of treatment did the person get?

What kinds of things have helped the person recover and stay well?

What questions would you like to ask the person in the video in order to better understand their experience with their illness?

MODULE 4

Activity #2

Teens and Parents (15 minutes)

In many cases, parents can be an important and needed support for teens. In some cases, this may not be possible, but there may be another trusted adult in a teen's life who can provide support. The relationship between a teen and a parent/parents or between a teen and a trusted adult can be challenging. To help teens and parents/other adults understand each other, the "How Do I Teen My Parent?" and "How Do I Parent My Teen?" resources may help.

Purpose:

- To make teens aware of these resources.
- To stress the importance of positive communications between parents and teens.

How-to:

- 1) Distribute or show the Teening My Parent and Parenting My Teen resources to pupils.
- 2) Allow 10 minutes of class time for pupils to review the resource.
- 3) Have the pupils write down one new piece of information that they learned from reading the resource to hand in as an in-class assignment. Review when class ends.
- 4) Encourage them to share the Parenting My Teen resource with their parent/parents or another trusted adult.

Seeking Help and Finding Support

Overview

How do we decide that what a person is experiencing is outside the range of the normal ups and downs we all go through? When is it time to seek assistance from health providers?

Seeking help and finding support for mental health problems or mental illness can be a tricky business. From the outside, it's often not clear when intervention is necessary, and people who are experiencing a mental illness may themselves not always be aware of what's going on, and can be reluctant to come forward for fear of being stigmatised.

When people know that they will not be stigmatised, and when they know where to go for help, they are more likely to seek help. Early intervention is important and increases the chances of recovery.

This lesson will address the issues around help seeking, as well as provide ideas about ways in which help and support can be accessed - within the school and beyond.

Learning Objectives

In this lesson pupils will learn to:

- Understand that people may need support to deal with some very stressful life events and situations
- Distinguish between “normal” responses to stress and those that may indicate a need for additional support from health professionals
- Get pupils to consider who they could talk to if they were worried about their own mental health, or that of a friend or relative
- Identify support personnel in the school relevant to mental health
- Become familiar with the range of community-based healthcare services and groups available to support people who are experiencing mental illness and their families and friends

Major Concepts Addressed

- Mental illnesses, like chronic physical illnesses, can be effectively treated
- Stigma acts as a barrier to people seeking help for mental illness
- Getting help early increases the chances that a person will make a full recovery from mental illness
- Recovery from mental illness is possible when a range of evidence-based treatments and supports are available
- There are many different things a person can do to seek help

Teacher Background and Preparation

- Read through all activities and handouts before class
- Preview PowerPoint: Treatment and Recovery
- Compile a list of community mental health resources for pupils and find out local pathways to care

MODULE 5

Preparation

Activities

- Activity 1: PowerPoint Presentation: Treatment and Recovery (15 min.)
- Activity 2: Getting Help (20 min.)
- Activity 3: My Health Questions (20 min.)
- *Optional Activity - Activity 4: Support Strategies (Homework)*

In Advance

- Fill out the Community Mental Health Resources list for your class (found on the next page)
- Preview PowerPoint
- Set up computer(s) to view PowerPoint
- Prepare cards

Online Supplementary Materials

The supplementary materials are designed to enable you to challenge pupils in your class to learn more about different mental disorders. These may or may not be resources you wish to employ. Please review them and decide if and how you wish to use them. If you are also using Teacher Knowledge Update, print as many copies as you think will be necessary for your class.

Useful Links

National Centre for Mental Health (NCMH):
<https://www.ncmh.info/>

National Health Service:
<https://www.nhs.uk>

National Institute for Mental Health (NIMH)
www.nimh.nih.gov/

Royal College of Psychiatrists:
www.rcpsych.ac.uk

Useful Self-Education

Action for Children: Mental Health Resources and Information

<https://www.actionforchildren.org.uk/support-for-parents/children-s-mental-health/how-can-you-help-with-children-and-young-peoples-mental-health/mental-health-resources-and-information/>

Template - Community Mental Health Resources

The following mental health related resources are available in many communities including youth-oriented programs. Find out the contact information for these resources in your community and distribute to pupils. The school counsellor, psychologist or social worker may be a good resource to include in the preparation of this information.

School Resources:

- School-based counsellor
- Social worker/ Youth Worker
- Nurse
- Peer support

Local Community Resources:

- Crisis/distress lines
- Mental health lines
- Youth centres
- Drop-ins
- Community health centres
- Hospitals/clinics
- Peer support groups

Mental Health Information (National):

- National Centre for Mental Health (NCMH) (<https://www.ncmh.info/>)
- National Health Service (<https://www.nhs.uk>)
- National Institute of Mental Health (<https://www.nimh.nih.gov/>)
- Royal College of Psychiatrists (<https://www.rcpsych.ac.uk/>)
- Teen Mental Health (www.teenmentalhealth.org)

Childline <https://www.childline.org.uk> - 0800 1111

A place a child or young person can talk to someone about something they are worried about. They can do this online or over the phone. 08001111

MODULE 5

Activity #1

PowerPoint Presentation: Treatment and Recovery (15 minutes)

Purpose:

- The PowerPoint “Treatments and Recovery” discusses the treatments that are available and what they do, as well as what recovery means.
- Pupils should understand that most mental disorders can be effectively treated and help-seeking is the key to recovery.

How-to:

- 1) Use the web version of the presentation by logging on to:

www.actionforchildren.org.uk/TheGuide

The password is: **GuideCymru**

Classroom Discussion

Lead a classroom discussion about what the pupils thought was important from their exposure to the PowerPoint presentation.

Getting Help (20 minutes)

Purpose:

- To describe a range of scenarios in which it would be important to tell or refer a problem to an appropriate adult.

How-to:

- 1) Explain to pupils that they will be engaging in a problem-solving lesson in which they can speculate about the possible actions they could take in a range of situations involving young people in distress. They will explore the scenarios using a game.
- 2) Ask pupils to arrange themselves into groups of four to six. Get them to sit in a circle (on the floor might be easiest).
- 3) Hand out the set of cards from the Activity Sheet: What if... scenarios. Ask each group to lay out their What if... cards in a circle with enough room inside the circle to spin a bottle or pen.
- 4) In turn, each of the participants takes a spin, and read out the card the bottle points to. The person whose turn it is speculates first about what to do in such a situation, then others help out by adding their views, questions or challenges.
- 5) When they have finished discussing the scenarios, ask the class to come back together and pose the following questions:
 - Were there any disagreements in the groups about what was best to do?
 - Which was the scenario most likely to actually happen out of those you discussed?
 - Which do you think would be the hardest scenario to deal with if it happened to you or a friend or family member?
 - What sorts of fears or concerns would stop people from seeking help or telling someone else in these situations?
 - What kinds of things would motivate someone to seek help or tell someone their concerns in the situations you discussed?
- 6) Distribute "Something Is Not Quite Right" checklists and read them through with the class.

Remind pupils that communicating their concerns about coping and dealing with mental health and other difficulties is really hard, and takes a lot of courage.

It's a good idea to anticipate potential student disclosures and to be prepared to deal properly with these situations. Ask the school social worker to be on hand if possible.

MODULE 5

Activity #2 Handout

What if.....Scenarios

- 1** Your friend seems really down and talks about dropping out of school.
- 2** A friend has been on a diet, is getting really skinny and never seems to eat. They think they're really fat and will not wear shorts or a bathing suit.
- 3** Since your dad left, your sibling is spending almost all of their time smoking, drinking and watching TV, and never wanting to do anything else. You have not told your friends about your parents splitting up.
- 4** There is a situation at school that is really stressing you out. Everyday when you wake up, you remember the situation and start to feel sick.
- 5** Your friend says they would be better off if they ran away. Your friend has already been sleeping over at your house a lot lately.
- 6** Someone in your class has started smoking marijuana before school everyday. The friends who smoke with this person only do it occasionally on the weekends. People are joking about how they are behaving – out of it and spacey. The person seems pretty down to you.
- 7** Your friend has started taking different kinds of pills at school, and is asking other people for painkillers all the time.
- 8** Your friend isn't acting like their old self. They seem really down, and have been doing strange things like giving their favourite things away. They recently told you that they thought people they knew would be better off without them around, and that they'd thought about killing themselves. After they tell you, they ask you not to tell anyone else about what they've said.
- 9** A kid in your class often gets completely ignored and occasionally teased and even bullied. No one will ever be seen talking to this person. The teachers don't seem to notice, and no one does anything to this kid when teachers are around.
- 10** A friend has started skipping a lot of school and seems pretty down.
- 11** Your friend has a parent with mental illness. From time to time, when the parent isn't doing well, your friend has to do everything at home. None of your other friends know about the situation. Your friend doesn't even know that you know. Your mom found out through a neighbour.
- 12** A classmate who is not really your friend, but is not friends with anyone else either, has started acting really strangely. Other kids have been laughing and making fun of them, but underneath you think this is a bit scary, and maybe the person is not doing this on purpose.

Something is Not Quite Right: Getting Help Early for Mental Illness

You have a feeling that something is “not quite right” about the way someone close to you is behaving. You’re worried, but you’re not sure if it might be serious, or if moodiness, irritability and withdrawn behaviour is a stage they’ll grow out of. Could drugs be involved? Do you think you might need a professional opinion to help you decide if there is a serious problem?

Getting Help Early

The chances are that there is not a serious problem, and that time, reassurance and support are all that are needed. However if a mental illness is developing, then getting help early is very important.

Being unwell for a shorter time means less time lost at school or work and more time for relationships, experiences and activities which help us stay emotionally healthy.

Checklist #1: Difficult behaviour at home, at school or in the workplace

Behaviour which is considered “normal” although difficult:

People may be:

rude weepy thoughtless irritable argumentative over-sensitive

over-emotional lazy withdrawn rebellious shy

These behaviours may also occur as a normal, reaction to stressful events such as:

breakup of a close relationship moving divorce other family crisis

death of a loved one other personal crisis exam failure physical illness

Probably no cause for serious concern, but...

It is often best to try not to overreact. Try to be as supportive as possible while waiting for the “bad patch” to pass. If the behaviour is too disruptive or is distressing to other people, or if the difficult behaviour lasts a long time, then you could seek professional counselling, help or advice. Talk it over with your family doctor, school counsellor, community or mental health centre.

*Adapted from *MindMatters: Understanding Mental Illness*, Pg. 77-79

MODULE 5

Activity #2 Handout

Checklist #2: What's the difference between just having a bad day and something potentially more serious?

Signs of Clinical Depression:

- Feeling sad and miserable for most of the day
- Feeling like crying much of the time
- Not wanting to do anything, go anywhere, see anyone
- Having trouble concentrating or getting things done
- Feeling like you're operating in "slow motion"
- Having trouble sleeping
- Feeling tired and lacking energy – being unable to get out of bed even after a full night's sleep
- Having a change in appetite - usually a loss of appetite
- Feeling hopeless
- Thinking of suicide
- Always putting yourself down and thinking you're not good or that nothing really matters

If you often experience most of these things everyday for a number of weeks in a row – you may have Depression. If that is the case, make an appointment with your school counsellor to discuss how you feel. Remember that you don't have to be alone with these feelings, and that Depression is treatable!

Checklist #3: Behaviours which are considered ABNORMAL for that person, and may seriously affect other people.

People may:

- Withdraw completely from family, friends, classmates and workmates
- Be afraid to leave the house (particularly during daylight hours)
- Sleep or eat poorly
- Sleep by day and stay awake at night, often pacing restlessly
- Be extremely occupied with a particular theme, for example, death, politics or religion
- Uncharacteristically neglect household or parental responsibilities, or personal appearance or hygiene
- Deteriorate in performance at school or work
- Have difficulty concentrating, following conversation or remembering things
- Talk about or write things that do not really make sense
- Panic, be extremely anxious, or significantly depressed and suicidal
- Lose variation in mood – be “flat” – lack emotional expression, for example, humour or friendliness
- Have marked changes in mood, from quiet to excited or agitated
- Hear voices that no one else can hear
- Believe, without reason, that others are plotting against, spying on, or following them, and be extremely angry or afraid of these people
- Believe that they are being harmed or asked to do things against their will, by, for instance, television, radio, aliens, God or the devil
- Believe they have special powers, for example, that they are important religious leaders, politicians or scientists
- Believe that their thoughts are being interfered with or that they can influence the thoughts of others
- Spend extravagant or unrealistic sums of money

Seek medical assessment as soon as possible. These types of behaviours are much clearer signs that someone needs to be checked out, particularly if they have been present for several weeks. They may be only a minor disturbance, but a mental illness such as a psychotic disorder may be developing.

MODULE 5

Activity #3

My Health Questions (20 minutes)

Purpose:

- To provide each pupil with a number of questions that they should routinely use when they discuss recommended treatment with their health provider.

How-to:

- 1) Direct the pupils to <http://teenmentalhealth.org/toolbox/communicating-health-care-provider-every-person-ask/>. Have them download or print the resource there.
- 2) Ask each pupil to carefully read the document and choose one or two questions from each category that they would like to use as their “go to” questions when visiting a health care provider.
- 3) Have each pupil create their own personal “My Health Questions” file and save it to their preferred electronic device.

Another useful resource for pupils when visiting their GP for the first time can be found at: <https://www.docready.org/#/home>

MODULE 5

Activity #4 (Optional)

Support Strategies (Homework)

Purpose:

- To provide pupils with strategies for supporting friends and others who are having trouble coping because of mental health problems or mental illness.

How-to:

- 1) Provide the handout to each pupil. Tell them that their homework will be to read the handout and write a one paragraph report on: if I had a friend who has a mental illness, one way that I could support them would be. Collect the reports in the next class (if you wish you can use the reports to help assign a grade).

Make sure to emphasize that everyone has a personal responsibility to take action if a friend mentions thoughts of suicide. Young people should always share this information with a trusted adult – like a teacher, guidance counsellor, coach, relative or parent – and never promise to keep the information secret.

*Adapted from Lesson 4 of Coping - *MindMatters*.

MODULE 5

Activity #4 Handout

Support Strategies

Here are some strategies for supporting someone with a mental health problem/illness:

- Be supportive and understanding.
- Spend time with the person. Listen to them.
- Never underestimate the person's capacity to recover.
- Encourage the person to follow their treatment plan and to seek out support services. Offer to accompany them to appointments.
- Become informed about mental illness.
- Remember that even though your friend may be going through a hard time they will recover.

Stand by them.

- If you're planning an outing to the cinema or shopping centre, remember to ask your friend along. Keeping busy and staying in touch with friends will help your friend feel better, when they're ready.
- If you are a close friend or family member of someone who has a mental illness, make sure you get support as well. Crisis training, self-help and/or individual counselling will help you become a better support person.
- Put the person's life before your friendship. If you think the person needs help, especially if they mention thoughts of suicide, don't keep it a secret – even if the person asked you to.

If a friend mentions thoughts of suicide or self-harm, you **NEED** to tell their parents, a teacher, guidance counsellor or someone else who can help. It's better to have a friend who's angry with you for a while than to keep their secret and live with knowing you could have helped but remained quiet when your friend was in trouble.

Recovery – What Helps People With Mental Illness Get (and Stay) Better?

Recovery is an ongoing, slow process, and is different for each person. Research on recovery shows that there are a number of factors which people often mention are important:

- The presence of people who believe in and stand by the person who is in recovery.
- That person's ability to make their own choices about important things like treatment and housing.

Other factors that can support recovery include:

- Mutual support (self-help groups)
- Social opportunities (church groups, drop-in centres, volunteer work, participating in community life)
- Positive relationships (accepting and being accepted, family and friends and communicating with them in a positive way)
- Meaningful daily activity (being able to work, go to school)
- Medication (sticking with a treatment plan, working with doctors to find the best medications with the fewest side effects)
- Spirituality (involvement in a faith community or individual spiritual practice)
- Inner healing capacity and inner peace (finding a sense of meaning and purpose, even in suffering)
- Personal growth and development (hobbies, self education, taking control of one's life, exercise, personal goal setting)
- Self-awareness (self-monitoring, recognising when to seek help, recognising one's accomplishments and accepting and/or learning from one's failures)

MODULE 6

Preparation

The Importance of Positive Mental Health

Overview

What constitutes a mentally healthy person? Does being mentally healthy mean not having negative emotions? What does the word “stress” mean and how can we re-think the common perception that all stress is bad for our mental health? Are the strategies that we use to achieve good mental health mostly different or mostly the same as those we use to achieve good physical health?

Learning Objectives

In this lesson pupils will:

- Learn about what the stress response is and how to use it to help develop resilience
- Learn when to apply stress reduction techniques and what kinds of stress reduction techniques can be helpful
- Learn and apply activities designed to enhance both mental and physical health

Major Concepts Addressed

- Everyone has mental health even if a person has a mental illness
- Learning what the stress response is and how to use it can help a person better adapt to life and develop resilience
- Strategies that we use to develop good mental health are very similar to those we use to develop good physical health

Teacher Background and Preparation

- Read through all activities and handouts before class
- Review the Kelly McGonigal TED Talk, *How to make stress your friend*, (<https://www.youtube.com/watch?v=RcGyVTAoXEU>) and ensure you understand and can explain the handouts that will be provided to pupils (note that there is BOTH a teacher and student version of Handout 6.2)

Activities

- Activity 1: Understanding the Stress Response (25 min.)
- Activity 2: Challenging our Thinking (10 min.)
- Activity 3: Reviewing Useful Strategies for Modulating the Intensity of the Stress Response (10 min.)
- *Activity 4 - Optional Activity: Taking Charge of My Health (homework)*

MODULE 6

Preparation

In Advance

- Photocopy handouts 6.1, 6.2 and 6.3 for each student
- Set up projection equipment to play the Kelly McGonigal TED Talk video
- Cut out “Coping with Stress” cards and place in an easily accessible location in the classroom
- Prepare video ready link to <https://gearpatrol.com/2017/02/02/box-breathing-navy-seals/>
- Photocopy “Box Breathing” card for each student

Materials Required

- Projection capability for classroom viewing of the Kelly McGonigal TED Talk video
- Handouts 6.1 and 6.2 (Note: for Handout 6.2 there is BOTH a teachers version and pupils version, please ensure you give pupils the student version of the handout)
- Challenging Our Thinking cards
- Coping with Stress cards
- Box Breathing cards
- Flip chart, flip chart paper, paper, pens, tape

Useful Self-Education

Carl Cederström and André Spicer
The Wellness Syndrome (Book, 2015)

JSTOR Daily: The False Promises of Wellness Culture
<https://daily.jstor.org/the-false-promises-of-wellness-culture/>

Ruby Tandoh: The Unhealthy Truth Behind ‘Wellness’ and ‘Clean Eating’
www.vice.com/en_us/article/jm5nvp/ruby-tandoh-eat-clean-wellness

MODULE 6

Activity #1

Understanding the Stress Response (25 minutes)

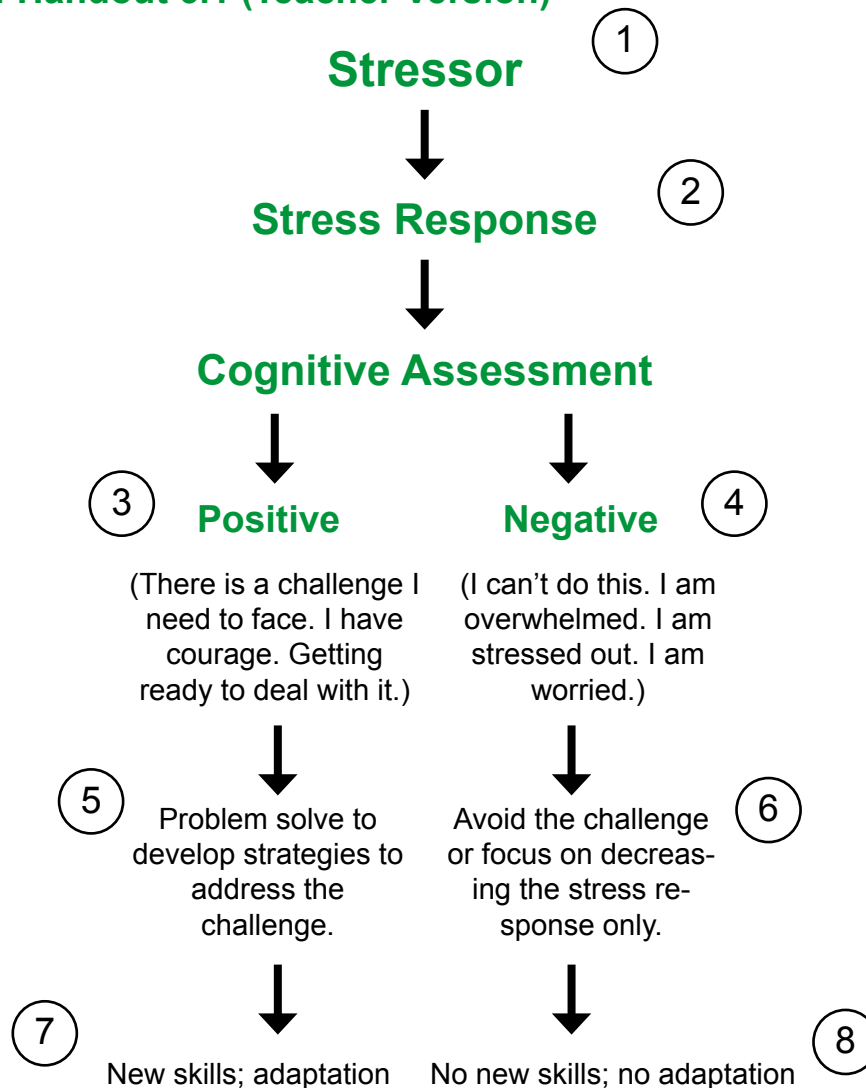
Purpose:

- To help pupils understand the stress response and its purpose (to alert persons to a challenge in their environment that must be addressed).
- To help pupils understand that successfully solving the challenge they are facing will both eliminate the stress response and will leave them with skills they can apply in future challenging situations. This is called building resilience.
- To help pupils better adapt to the usual challenges of life.

How-to:

- 1) Ask pupils to write down on a piece of paper what they think of when they hear the word “stress”.
- 2) Collect the pieces of paper and save for later in the lesson.
- 3) Distribute Handout 6.1 to all the pupils (make sure you give the pupils their version of this handout and that you have reviewed the teachers version of this handout) and explain what it demonstrates – focus on the negative impact of avoidance (enhances intensity of subsequent stress responses) during the stress response and the positive impact of persistence (decreases intensity of subsequent stress responses) during the stress response.
- 4) Play the Kelly McGonigal TED Talk, *How to make stress your friend*, (<https://www.youtube.com/watch?v=RcGyVTAoXEU>). During the video summarise item 1 responses into negative and positive categories (calculate numbers in each category). After the video is completed, provide a forum for class discussion. Some suggested topics: What did the presenter say that was different from what you have believed about stress? What did you take away from the presentation that you can use in your own life?
- 5) Distribute Handout 6.2 to all the pupils and explain what it demonstrates. Focus on the importance of cognitive “explanation” of the stress response and how two types of intervention (one – use cognitive techniques to help solve the problem that the stress response has identified; two – use stress modulation techniques to help decrease the intensity of the stress response) can be used. BOTH are necessary. Distribute Handout 6.3 which provides a step by step approach.
- 6) Now that they have been exposed to the handouts and have seen the video, ask pupils to write down on another piece of paper what they think of when they hear the word “stress”. Collect the pieces of paper.
- 7) Ask the pupils to write a short paragraph describing a time when they successfully dealt with a stress response that they experienced (for example: an examination, a social situation, a conflict with someone, etc.) in a way the video suggests doing. Let your pupils know that this is meant to be a private activity and will not be shared with classmates. During this activity summarise item 6 responses into negative and positive categories (calculate numbers in each category) and post outcomes from item 1 and item 6 responses on a flip-chart that all pupils can see.
- 8) Report to the class on the differences in the numbers of responses in negative and positive categories between activity 1 and activity 6. Lead an open discussion on why these differences occurred and on what the class has learned about the stress response and how they can apply what they have learned.

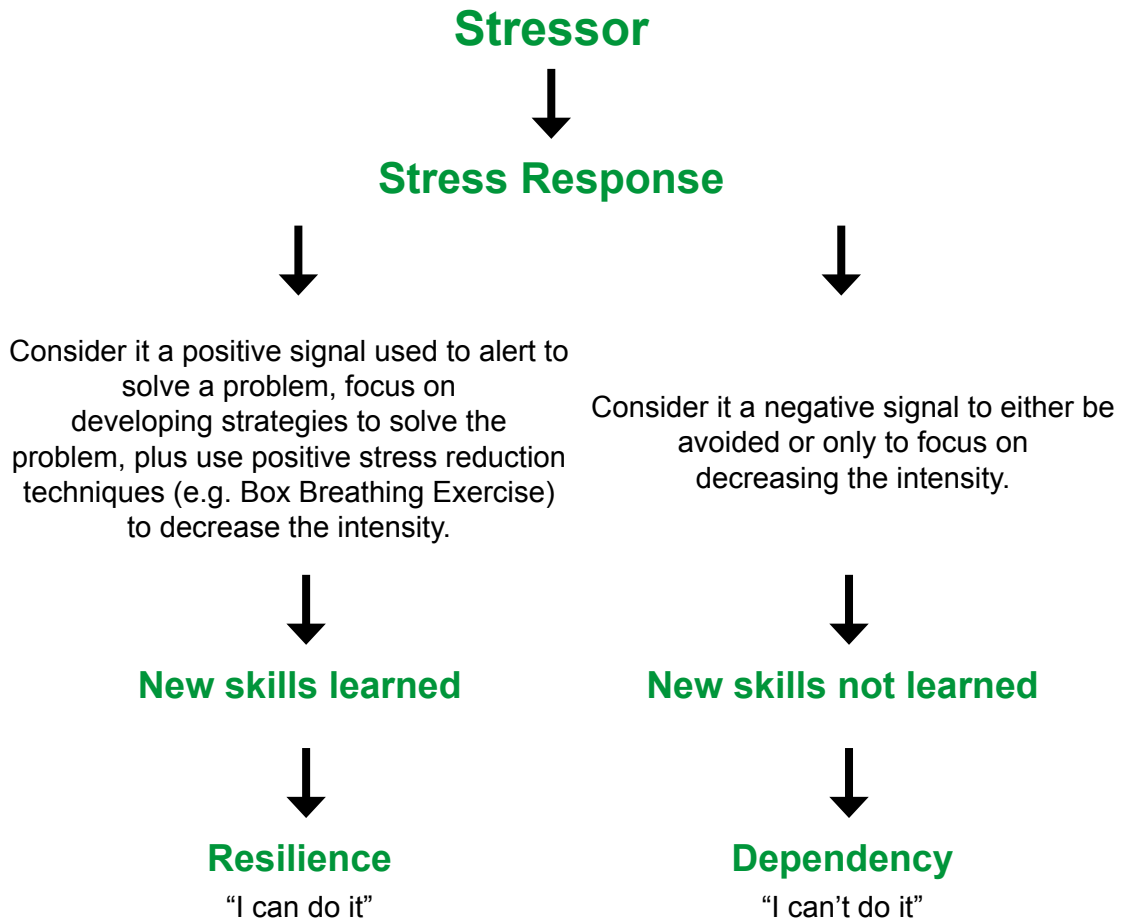
Explanation of Handout 6.1 (Teacher Version)



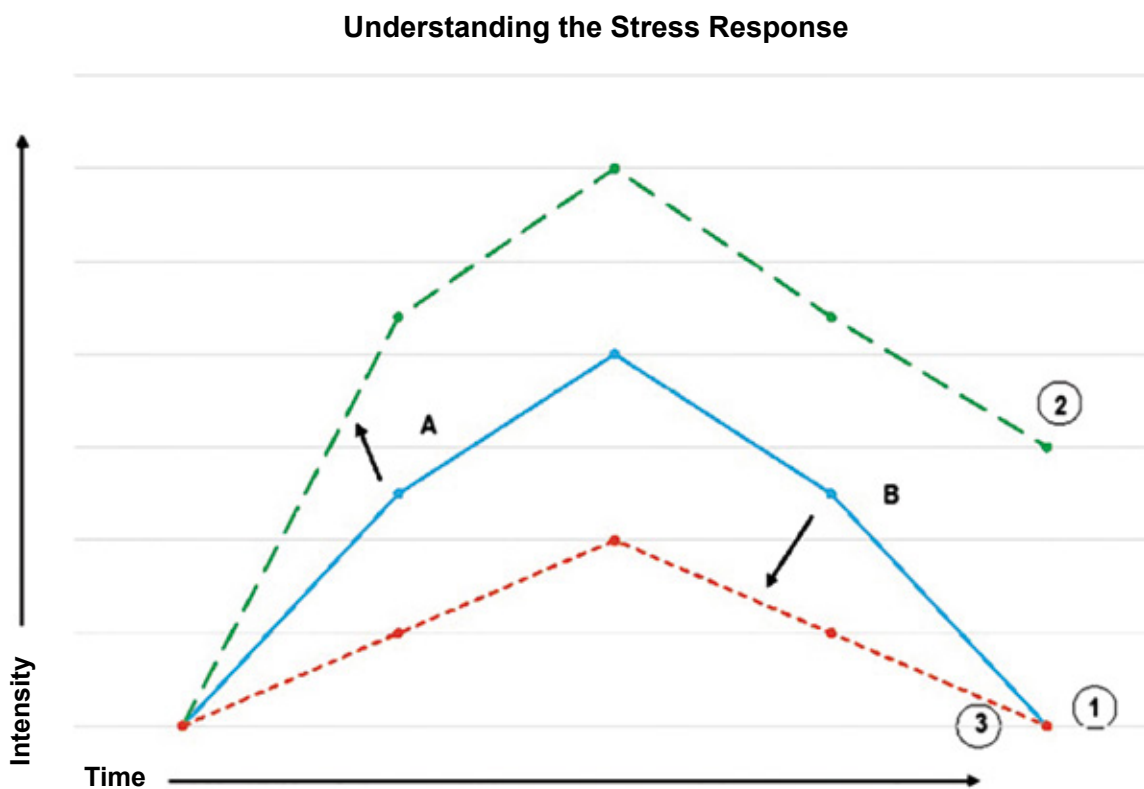
- 1) A challenge occurs in our environment (e.g. an upcoming exam).
- 2) We experience various “symptoms” (e.g. heart racing, rapid breathing, tension, etc.).
- 3) We understand this experience as a signal telling us we have a problem to solve.
- 4) We understand this experience as a signal telling us we have a problem we cannot solve.
- 5) We seek out solutions/strategies to help us solve the problem (e.g. study, ask for help, apply interventions designed to decrease intensity of the stress response).
- 6) We retreat, avoid and place focus on applying interventions designed to elevate intensity of the stress response.
- 7) We meet the challenge successfully and have learned new skills we can apply in the future (e.g. how to manage time, useful study skills, etc.).
- 8) We have not learned new skills and instead now expect that we can’t be successful and have learned to fear the stress response.
- 9) Repeated adaptations lead to resilience.

MODULE 6

Activity #1 Handout 6.1 (Student)



Understanding the Stress Response (Graph)



- 1) Normal stress response (physical, cognitive, emotional).
- 2) What happens to the stress response if a person avoids the situation (point to A on line 1). Next time the stressor occurs the response is more severe.
- 3) What happens to the stress response if a person uses their experience of stress to arrive at a solution (point to B on line 1). Next time the stressor occurs the response is less severe.

MODULE 6

Activity #1 Handout 6.3

Steps to Dealing with “Stress” in a Healthy Way

- 1) When you experience the stress response, make sure you use the right words to describe it. Use the phrase “stress response”. Do not use: “anxiety”, “stress”, “Depression”, “stressed out”, etc.
- 2) Interpret the stress response as positive. For example: “My body and brain are getting ready to take on an important task”, or “I am getting a signal telling me to get ready”.
- 3) Figure out what is causing the stress response. For example: “Why am I feeling the stress response?” or “What is happening in my life that is leading to the stress response?”
- 4) Figure out how to share the problem(s) causing the stress response. Make a plan. One step at a time. Challenge your assumptions. Don’t use all or nothing reasoning. Ask someone for help.
- 5) Apply your solutions to the problem.
- 6) While you are doing all these things, manage your stress response with a stress reduction technique such as Box Breathing.

Challenging Our Thinking (10 minutes)

Purpose:

- To help pupils put into their own words how others have described the purpose of the stress-response.

How-to:

- 1) Have five flip chart papers posted around the room, each with a heading from the list of Challenging Our Thinking cards.
- 2) Distribute the Challenging Our Thinking cards (note: more than one pupil will be given the same card) and ask the pupils to read what is written on the card.
- 3) Have the pupils write out in their own words the meaning of the Challenging Our Thinking card that they have just read.
- 4) Elicit volunteers to share what they have written as the meaning of their Challenging Our Thinking card (suggest at least two different pupils sharing their response for each card).
- 5) Have pupils post their responses to each of the card titles on the appropriate flip chart. Leave these up for a week.

MODULE 6

Activity #2 Handout

“

Challenging Our Thinking Card #1

Ships are safe in the harbour but that is not what ships are built for.

”

“

Challenging Our Thinking Card #2

A smooth sea never made for a skilled sailor.

”

“

Challenging Our Thinking Card #3

The roof of success has often been built on the foundation of failure.

”

“

Challenging Our Thinking Card #4

We cannot discover the other side of the ocean without the courage to lose sight of the shore.

”

“

Challenging Our Thinking Card #5

Don't let your worries decide your future.

”

Modulating the Intensity of the Stress Response (10 minutes)

Purpose:

- To help pupils differentiate positive from negative activities that they can do to lessen the intensity of the stress response.
- To review the Box Breathing technique of stress response modulation.

How-to:

- 1) Hand out the Box Breathing cards to each pupil. Remind them that this is a technique that they have been doing at the start of each class in this course and encourage them to keep using this technique to help modulate their own stress response.
- 2) Have the Coping with Stress cards available in an easily accessible location in the room.
- 3) Have flip chart papers titled Positive Coping and Negative Coping hung on different sides of the classroom. Have tape available for posting the cards on the flip charts.
- 4) Ask pupils to pick up two Coping with Stress cards each and to post them on the flip chart paper categories in which they best fit – Positive Coping or Negative Coping.
- 5) Keep the posted lists up in the classroom for one week following the end of this activity.

Box Breathing

One useful technique to help with dealing with stress is Box Breathing. It takes about 15 minutes to learn and once mastered can be applied unobtrusively and quietly – ideal for a classroom situation. This technique is described below. Before beginning the How Do You Cope exercise would be a good time to teach the pupils Box Breathing.

Box Breathing can help your heart rate return to normal, which helps you to relax. Here's how you do it: If possible, sit and close your eyes. If not, just focus on your breathing.

Step 1: Inhale your breath (preferably through your nose) for 4 seconds.

Step 2: Hold your breath for 4 seconds. You're not trying to deprive yourself of air; you're just giving the air a few seconds to fill your lungs.

Step 3: Exhale slowly through your mouth for 4 seconds.

Step 4: Pause for 4 seconds (without speaking) before breathing again.

Repeat this process as many times as you can. Even 30 seconds of deep breathing will help you feel more relaxed and in control.

MODULE 6

Activity #3 Handout

Coping With Stress Cards

Withdraw – not mix with other people

Play computer games

Visit a favourite person

Eat more

Quit (the job, the team)

Avoid or put off something you have to do

Prioritise
(put the most important things first)

Fantasize (daydream an escape)

Plan (figure out how to do it)

Start a fight

Think positively about how it will turn out

Worry

See a counsellor

Eat junk food

Sleep more

Go for a run

Party/socialise

Run away

Get sick

Blame someone else

MODULE 6

Activity #3 Handout

Coping With Stress Cards

Blame yourself

Ask for help

Talk it over

Eat less

Have a shower

Drink alcohol

Work harder

Meditate

Pretend it's okay

Watch television

Smoke cigarettes

Go out

Complain

Change direction

Go to bed early

Exercise

Stay out late

Listen to music

Call friends

Write about it

MODULE 6

Activity #3 Handout

Coping With Stress Cards

Walk the dog

Cook something

Pray

Take a day off

Take risks

Problem-solve

Cry

Set goals

Play sports

Sleep less

Go shopping

Draw or paint

Tidy up

Make something

Find new friends

Joke or laugh

Go for a swim

MODULE 6

Activity #4 (Optional/Homework)

Taking Charge of My Health

Purpose:

- To reinforce that mental health and physical health are obtained and maintained with numerous similar strategies.
- To provide a diary experience of daily activities needed to obtain and maintain good mental health.

How-to:

- 1) Introduce the pupils to the resource Taking Charge of My Health (provide each pupil with a copy of the resource with enough pages for a week of diary keeping).
- 2) Instruct each pupil each day to choose one item from each of the diary sections as their “next day challenge” and to try and complete each of those challenges the next day.
- 3) Ask the pupils to do this daily for a week. Also, do it yourself to model how.
- 4) Review the exercise a week from now. Lead a classroom discussion. How many challenges did each pupil manage to keep daily (on average)? How did they find the exercise (tiring, difficult, enjoyable, etc.)? What did they learn from doing this exercise?

Glossary

Acute: means that something (usually a disorder or a symptom) has come on quickly with a high degree of impact on a person.

Addiction: is continuing to use a substance (for example: alcohol or cocaine) for nonmedical purposes despite wanting or trying to stop using it. Addictions have a negative impact on many areas of a person's functioning in life. For example, if a person's substance use gets in the way of positive relationships with friends or family, success at school or work or it is interfering with their life. An addiction is characterised by: abuse of a chemical, behaviour of drug seeking and daily focus on the drug; craving for the substance. People who are addicted will often experience withdrawal when they stop using a substance. But, withdrawal does not equal addiction. Withdrawal is a common physical response to quickly stopping a chemical that affects the brain.

Affect: is the emotional experience that someone feels inside of themselves that can be recognised by others. For example: if you are looking/acting sad you can be recognised by someone else as you are feeling sad.

Agoraphobia: a fear and avoidance of situations where you might feel unsafe or unable to escape if you have a panic attack.

Anhedonia: is a word used to describe a lack of pleasure. Sometimes, people suffering with Depression will experience anhedonia. For example, the person doesn't feel good when they are doing things that normally make them feel good, such as playing a favourite game, swimming, watching movies, etc. Anhedonia due to Depression will get better once the Depression has been successfully treated.

Anorexia Nervosa (commonly referred to as Anorexia): is a type of eating disorder. The main features that a person with Anorexia will experience are: refusing to maintain a minimally reasonable body weight, intense fear of gaining weight, and an unrealistic perception of their body image (for example: they think or feel that they are much larger or heavier than they actually are). The word "anorexia" means loss of appetite but many youths with anorexia actually struggle to suppress their appetite. Anorexia Nervosa can be effectively treated with various psychological and family focused therapies.

Antidepressant medicine: a medicine that is usually used to treat the symptoms of Depression or anxiety disorders. The antidepressant called "fluoxetine" is considered to be the most useful for helping in adolescent Depression. It usually takes 6 to 8 weeks for an antidepressant medicine to work in treating Depression.

Antipsychotics: are medicines that are often used to help treat psychosis. Sometimes they can also be used to treat mood swings (such as severe Depression or Mania) or extreme behaviours (such as aggressive outbursts). This can be confusing if a person is being treated with an antipsychotic medicine and does not have a psychosis. If you are being treated with an antipsychotic medicine make sure you understand why it is being used and its risks and benefits. Check out the "Evidence Based Medicine for Teens" on: www.teenmentalhealth.org.

Anti-social personality disorder: is a type of personality disorder. People with anti-social personality disorder have a long pattern of violating the rights of others. It begins in childhood or early adolescence and continues into adulthood. Other common terms for anti-social personality disorder are sociopath or psychopath. People with this personality disorder will often harm others without feeling remorse or guilt.

Anxiety: is a type of body signal, or group of sensations that are generally unpleasant. A person with anxiety experiences a variety of physical sensations that are linked with thoughts that make them feel apprehensive or fearful. A person with anxiety will often also think that bad things may happen even when they are not likely to happen. For example, you may be thinking about your puppy falling and getting hurt

Glossary

when it is on the bed and this makes you feel anxious. Anxiety is normal and everyone experiences it. It is a signal that we need to adapt to life's challenges by learning how to cope. When you have so much anxiety that it interferes with your normal routine or many parts of your life such as, school, work, recreation, friends or family — that is when it becomes a problem and maybe even a disorder. Typical sensations of anxiety include: worry, ruminations, “butterflies”, twitchiness, restlessness, muscle tension, headaches, dry mouth, feeling as if air is not coming into your lungs, etc.

Anxiety Disorders: are a group of common mental disorders. People with an Anxiety Disorder will experience things like mental and physical tension about their surroundings, apprehension (negative expectations) about the future, and will have unrealistic fears (see anxiety). It is the amount and intensity of the anxiety sensations and how they interfere with life that makes them disorders. Some common types of Anxiety Disorders are: Social Anxiety Disorder, Panic Disorders, Separation Anxiety Disorder, Generalised Anxiety Disorder, etc. Anxiety Disorders can be effectively treated with psychological therapies or medications.

Asperger's: is often considered to be a developmental disorder that can usually be diagnosed prior to adolescence. People with Asperger's experience repetitive and restrictive behaviours and interests that may lead to impaired functioning at work and socially. Asperger's is considered one of the several disorders on the Autism Spectrum and is unique because there is no significant delay in language development. Many people with Asperger's live full and productive lives without any (or minimal) treatment. Recent research is challenging the idea that Asperger's is a disorder but much more study of this is needed.

Attention Deficit Disorder (ADD): is a term used in the past to diagnose what is now called ADHD (see Attention Deficit Hyper-Activity Disorder).

Attention Deficit Hyper-Activity Disorder (ADHD): is a mental disorder that is usually lifelong and associated with a delay in how the brain matures and how it processes information. People with ADHD usually have varying degrees of difficulty paying attention, being impulsive, and being overactive which causes problems at home, in school, and in social situations. There are three kinds of ADHD: Inattentive Type, Hyperactive-impulsive Type and Combined Type. People with Inattentive Type mostly have problems paying close attention to things or being able to pay attention for long periods of time, so it is harder for them to focus on schoolwork or things that take a lot of concentration for more than a short period of time. People with Hyperactive-Impulsive are usually “on the go” and are often not very good about thinking things through before they act. People with Combined Type have problems with inattention and hyperactivity/impulsivity. ADHD can be treated effectively with medication and behavioural techniques. About 1/3 of young people with ADHD may have a learning disability, so anyone who is diagnosed with ADHD should have special learning tests done.

Atypical antipsychotics: are newer types of medicines that help treat psychosis. Sometimes they can be used to treat mood swings (such as severe Depression or Mania) or extreme behaviours (such as aggressive outbursts). See Antipsychotics above.

Autism Spectrum Disorder (ASD): is a life-long mental disorder in which the person suffers with significant abnormal development of social interaction, verbal and non-verbal communication. A person with Autism has trouble understanding the feelings of others (empathy) and usually does not understand many social norms (rules that tell us what is socially acceptable). Language difficulties range from the inability to speak to automatic sounding repetitive phrases to normal language that sounds formal and emotionless. People with Autism Spectrum Disorder may also display repetitive behaviours (for example: continuous flapping of hands) and a strong need to follow a precise daily schedule and routine. Autism symptoms can vary from extremely severe to mild. Numerous treatments are available to help improve many of the symptoms of Autism, but as of yet there is no single best treatment for Autism. The causes of Autism are complex and not well understood but the popular perception that vaccinations cause Autism is not correct.

Glossary

Avolition: means having little or no motivation or drive to do things. For example, not getting dressed or not wanting to go out with family or friends. This is not the same thing as “lazy”.

Axon: is the long, fibre-like part of a nerve cell (neuron) in the brain or spinal cord by which information is carried to other nerve cells.

Benzodiazepines: are medications that are used to treat a number of different mental disorders – most commonly anxiety. They can also be used to treat severe restlessness and agitation. When properly used they can be very helpful.

Bipolar Disorder (manic Depression): is a mood disorder. People with Bipolar Disorder have experienced at least one full depressive episode and at least one manic episode. Most people with Bipolar Disorder have their first episode before age 25 and it is usually a Depression. Bipolar Disorder can be effectively treated with medications and various psychological therapies.

Bipolar Disorder type 2 (hypo-manic Depression): is a mood disorder. People with Bipolar Disorder type 2 experience at least one full depressive episode and at least one hypo-manic episode. Hypo-manic episodes are similar to manic episodes but are not as severe. These episodes may last days to months. Bipolar Disorder type 2 can be effectively treated with medications and psychological therapies.

Borderline personality disorder (BPD): is a personality disorder. People with borderline personality disorder have difficulty in regulating their emotions and can experience intense bouts of anger, Depression, and anxiety that may last from hours to days or longer. These bouts occur over and over again, often in response to minor life stressors or just on their own. People with BPD have unstable moods, stormy relationships, poor self-image, and self-harming behaviours which can lead to impulsive aggression, self-injury, risk taking and substance abuse.

Brain: is the center of: adaptation, exploration, procreation and civilisation. It is the master control of you and your body. You are what your brain is. Your mind is what your brain does. The brain is made up of many different parts that are all connected with each other. Here is a very brief overview of some of the parts and some of what they do.

Amygdala: is responsible for emotional memories, responses to fear, emotions and arousal, as well as being involved in the release of hormones that prepare the body for action.

Brain stem: relays messages from the body to the rest of the brain (cerebrum & cerebellum) and vice versa. It also helps control many of the body's vital functions, such as breathing, digestion, heart rate, sleep and arousal.

Cerebellum: is important for coordinating movement, controlling balance and muscle tone.

Cerebrum: is the largest part of the brain responsible for “higher functions” such as concentration, reason and abstract thinking. It consists of two connected hemispheres (halves) that are divided into the following four lobes: frontal, occipital, parietal and temporal.

Frontal lobe: is important in controlling movement, planning behaviour (actions), reasoning, emotions, and problem solving.

Gray matter: is the part of the brain that is dark in color. It is mostly made up of nerve cells (neurons).

Glossary

Hippocampus: is involved in turning emotional information into memory, learning, and regulating (controlling) emotional responses.

Hypothalamus: communicates with the limbic system to influence behaviour and emotions, controlling body functions such as temperature, sleep, appetite, sexual drive and stress reactions. Also helps control hormone release from the pituitary gland of the brain-endocrine system.

Limbic system: is made up of a group of brain parts that help control emotions, memory, motivation, appetite, and arousal.

Locus Coeruleus: is a small area in the brain stem containing nerve cells that activate the norepinephrine system that signals anxiety and fear.

Myelin: is a kind of insulation that covers axons and helps nerve signals move more quickly. Myelin is also often called “white matter” because it looks white.

Occipital lobe: is responsible for vision.

Parietal lobe: is responsible for recognition (i.e. knowing what things are), body movement in space, as well as taste and some touch.

Temporal lobe: is important in the processing (i.e. knowing what things mean) and recognition (i.e. knowing what things are) of sounds as well as the recognition and memory of objects and faces.

Thalamus: receives information from all parts of the nervous system and relays it to the appropriate parts of the brain that deal with sensation and motor (movement) signals. It also helps to regulate sleep and wakefulness.

To learn more about the brain, check out the brain information sections on this website: www.teenmentalhealth.org.

Bulimia Nervosa: is an eating disorder often just called Bulimia characterised by excessive uncontrollable eating (binges of large amounts of food) over a short period of time, which is then followed by actions that try to get rid of the calories consumed (e.g. vomiting, laxative abuse, excessive exercise). This behaviour is repetitive and often followed by feelings of Depression, self-disgust, and guilt. Bulimia can be effectively treated with psychological therapy or medications.

Calorie (also known as kilocalorie): a unit of measurement to calculate heat expenditure or energy. It is often used to determine how much energy is in food or how much energy is used in physical activity. For example an apple may contain 80kcal of energy or a person may use 50kcal walking down stairs.

Cerebellum: look under **Brain**.

Cerebrum: look under **Brain**.

Chronic: something that is there most of the time for a long time. Often used to describe a disorder that lasts for years or more.

Circadian Rhythm: is the body’s biological clock with a cycle of about 24 hours. It helps control our sleep and wake cycle as well as temperature and hormone variations.

Glossary

Clinic: is a setting where various health professionals work directly with patients.

Clinical: an activity that takes place between a health provider and a patient (for example: diagnosis, treatments, etc).

Cognition: the mental processes associated with thinking, learning, planning, memory etc.

Cognitive Behavioural Therapy: is a form of psychotherapy (talk therapy), designed to help treat various mental disorders. It focuses on changing the person's thoughts and behaviours to help reverse the person's symptoms and help increase the person's functioning.

Cognitive Symptoms: are disruptions in normal thoughts. Some medical disorders can interfere with cognition. For example: negative thoughts in Depression ("I am a useless person") or delusions (see below) in psychosis ("The FBI is plotting against me") or difficulties in planning or problem solving, etc.

Community treatment: means providing various kinds of treatments and services in the community instead of in the hospital. For example: in the doctor's office, in a health clinic or health centre, in a school, etc.

Community Treatment Order: is a legal document that allows or stipulates that a person with a mental disorder will receive treatment while they live in the community.

Comorbidity (also known as dual diagnosis): describes the presence of two disorders that may be associated in a person. For example, someone who has been diagnosed with a Substance Abuse Disorder of Alcohol and Depression.

Completed suicide: is the death of a person following a purposeful self-inflicted act with the intent to die. However, a more clear way of saying this is "die by suicide". It is important not to confuse self-harm with suicide attempts.

Computed Axial Tomography (CAT) Scan: is a special kind of X-ray that creates a picture of the structures of the brain – what the brain looks like.

Compulsions: are repetitive behaviours used to suppress (push out) obsessive thoughts or to follow strong urges. Some types of compulsions include: counting, checking, tapping, etc. While mild and occasional compulsions are common, severe and persistent compulsions can be part of Obsessive Compulsive Disorder.

Concussion: a concussion is a brain injury that is caused by a blow to the head or body that leads to problems with brain function due to brain damage. It can occur without a loss of consciousness and can be caused by what seems to be a mild blow or bump. A concussion can occur in any sport or recreational activity as a result of a fall or a collision or other mishap. A concussion can lead to many difficulties in thinking, emotions or behaviour and sometimes can lead to a mental disorder such as Major Depressive Disorder or Dysthymia. A concussion requires proper medical treatment. You can find out more about concussions in young people here: www.teenmentalhealth.org.

Conduct Disorder (CD): is a disruptive behaviour disorder. The individual with CD shows a persistent pattern of aggressive behaviours lasting over 6 months that are unacceptable to society. Examples include stealing, fighting, starting fires, etc. Young people with CD often get into difficulty with the law.

Consent: means to give approval or permission to someone to do something. For example a patient must give consent to receive treatment or to be a participant in a research study.

Glossary

Delusion: is a disturbance of cognition where a person has fixed false beliefs that something has occurred or will occur that is not real. A common delusion is the belief that someone is trying to harm them, even though nobody is. Delusions are often associated with psychosis.

Dendrite: are the specialised fibres that extend from a neuron's cell body and receive messages from other neurons (nerve cells).

Depressant: any substance (medication or drug) that slows down a person's thinking and/or physical functioning. Examples include some pain killers and alcohol.

Depression: is a term used to describe a state of low mood or a mental disorder. This can be confusing because people may often feel depressed but will not have the mental disorder called Depression. People with a Depression could be experiencing either Major Depressive Disorder or Dysthymic Disorder. The most common type of Depression as a mental disorder is a Major Depressive Disorder (MDD). A person with MDD feels very low/sad/depressed or irritable and also experiences: lack of interest, less pleasure, hopelessness, fatigue, sleep problems, loss of appetite, suicidal thoughts. MDD has a negative impact on a person's life, home, family, school/work, friends, etc. Depression can also be part of a Bipolar Disorder (see above). MDD can be effectively treated with psychological therapies or medications.

Depressive Episode: describes a period of Depression in MDD or Bipolar Disorder. It includes at least 5 or more of these symptoms being present, mostly every day for 2 or more weeks: depressed mood, a clear decrease in interest or pleasure in most or all (once enjoyable) activities, a significant weight gain or loss without dieting or loss of appetite, unable to get enough sleep or too much sleep (Insomnia or Hypersomnia), slow movements or purposeless movements from mental tension such as nervousness or restlessness, which is observable by others (also known as psychomotor agitation or retardation), feeling tired or having less than a normal amount of energy, feeling worthless or a lot of inappropriate guilt, diminished ability to think or concentrate, or indecisiveness (have difficulties making decisions), recurrent (happening again and again) thoughts of death, suicidal ideation (thoughts and/or ideas about death or dying), suicide plan, or suicide attempt.

Development: is physical and psychological (emotional and cognitive) growth throughout life.

Diagnosis: is a description that identifies a medical or mental disorder or illness. In North America a diagnosis is determined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) and by the International Classification of Diseases (ICD). A diagnosis is a medical act provided by doctors, psychologists and others trained in diagnosis. A diagnosis is not a label.

Disorder: an abnormality in mental or physical health; disorder is often used as another name for illness.

Distress: is mental or physical suffering. Distress is a part of normal life. Distress is not a mental disorder.

Double Depression: is a mental disorder which is characterised by the presence of both Major Depressive Disorder and a less severe Depression known as Dysthymic Disorder in one individual.

DSM IV –TR: is a diagnostic manual published by the American Psychiatry Association that names and describes mental disorders. It divides mental disorders into categories called diagnoses based on lists of criteria (signs and symptoms). Its name is the Diagnostic and Statistical Manual (DSM). The IV-TR refers to the version of the manual as it is updated over time.

Dysthymic Disorder: is a mood disorder. People with Dysthymic Disorder experience persistent low mood for two or more years (or one year for children) but experience fewer depressive symptoms than in Major

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Depressive Disorder. This low grade Depression can result in many difficulties at home, school, work, with family and friends. Dysthymia can be effectively treated with psychology therapies or medication.

Eating Disorders: are a group of mental disorders related to eating. People with (an) eating disorder(s) excessively control their eating, exercise and weight. These disorders include Bulimia, Anorexia Nervosa, Binge Eating Disorder, and Eating Disorder Not Otherwise Specified. Eating disorders can be effectively treated using various psychological and medical treatments.

Electro Convulsive Therapy (ECT): is a form of treatment for mental disorders in which improvements in the disorder are produced by the passage of an electric current through the brain. ECT is given with anesthetic and is most often used to treat severe mood disorders. Its name has the word convulsion in it which means “uncontrollable shaking”. This used to occur in the past but does not happen now because the electric current is given while the person is under anesthetic.

Electro-Encephalography (EEG): this is a technique that measures the electrical activity occurring in the brain by putting electrodes on top of a person’s scalp. It is often used to assess sleep disorders or to diagnose epilepsy.

Euphoria: this word means a much exaggerated sense of happiness or joy. In a mental disorder this can be found in Bipolar Disorder.

Evidence Based Medicine (EBM): is the standard of medical care that happens when the health provider uses the best available scientific information to provide the kind of care the patient needs. For how you can be sure that your health care provider (doctor, nurse, social worker psychologist, etc.) is using EBM check out the EBM materials (for young people and for parents) at www.teenmentalhealth.org.

Extraversion: a personality type where someone is very outgoing and sociable. People with this personality feature are often called “extroverts”.

Frontal lobe: look under **Brain**.

Functional Impairment: is a state in which a person is not functioning as they usually would or not functioning well in one or more area of life (i.e. family, friends, intimate relationships, work, school, etc.).

Functional Magnetic Resonance Imaging (fMRI): this is a method for studying how the brain is working. Pictures are taken of different changes that are created when blood flows through different parts of the brain. They help us better understand how the brain works when it is healthy and when it is sick (such as with a mental disorder).

Generalised Anxiety Disorder (GAD): is a mental disorder which is characterised by excessive anxiety and worry about numerous possible events (not any single, specific event) that leads to problems with daily functioning. People with GAD worry all the time and experience many physical symptoms because of the worry (headaches, stomach aches, sore muscles, etc.). GAD can be effectively treated with psychological therapies or medications.

Genetic disposition: this describes the probability that a disorder may be due to genetic factors passed on from parents to their children.

Grandiosity: is having a highly exaggerated and unsubstantiated belief in your importance, ideas or abilities. Unrealistic amounts of grandiosity can be found in Mania and Hypomania.

Glossary

Grief: is normal emotional suffering experienced by a person from a loss of a loved one (e.g. it is experienced when a family member dies). It is different from a depressive disorder. Grief is not a mental disorder.

Hallucination: is a disturbance of how your brain perceives the world. A person with hallucinations experiences senses that aren't real (i.e. sound, sight, smell, taste, or touch). For example, a person with psychosis is hallucinating if they hear voices that aren't occurring in reality.

Health: is a state of physical, mental, social, and spiritual wellbeing and not just the absence of disease or infirmity. It includes mental health.

Health Care Professionals: are the trained professionals who help with the care of people who are sick or who help people and communities stay well. Examples include: doctors, nurses, psychiatrists, psychologists, occupational therapists, social workers, etc.

Hippocampus: look under **Brain**.

Holistic: is used to describe a type of care that focuses on the whole person. It takes into account their physical and mental state as well as their social background rather than just treating the symptoms of an illness alone.

Hormones: are chemicals formed in one part of the body and carried to another body part or organ where they have an impact on how that part functions. They are important in growth, development, mood, and metabolism (food uptake and breakdown). For example, serotonin is a hormone in the brain that affects mood, growth hormones come from the pituitary gland to many parts of the body and affects growth, testosterone affects sexual functioning, etc.

Hospitalisation: being kept or staying in a hospital as a patient for doctors and other health care professionals to decide on a diagnosis and implement a treatment plan for the patient. Hospitalisation for a mental disorder is usually used only if the disorder is severe or the person is in a crisis situation.

Hypomanic Phase (Hypomania): is a milder form of a Manic phase. It is usually a part of Bipolar Disorder. Hypomania can be effectively treated with medication and psychological therapies.

Hypothalamus: look under **Brain**.

Illness: has the same meaning as disease. However, having an illness can mean you have one disease or multiple diseases.

International Classification of Diseases of the World Health Organisation (ICD): is a book that classifies medical conditions (disorders and diseases) and groups of conditions. These conditions are determined by an international expert committee. This system is used worldwide for all medical diagnoses including mental disorders.

Introversion: means to look inward, for a person to mostly focus on their inner selves and less on their social surroundings. People that have this personality characteristic are often called "introverts".

Glossary

Involuntary status: is a term used to describe someone who has been admitted into a psychiatric facility (usually a hospital) against their will or without their consent, under the authority and protection of the law.

Knowledge Translation: is similar to changing a document from English to French. It is usually used in reference to changing scientific information into a format that can be easily understood for a specific group of people (e.g. children, adolescents, teachers, adults not in a scientific professional setting, etc.). It is also used to describe how best scientific evidence can be used to improve the care of patients by health professionals.

Locus Coeruleus: look under **Brain**.

Manic Phase: is one of the two phases of Bipolar Disorder (the other is Depression). It is a period of time during which the person with Mania experiences very high energy and excessive activity elevated to the point where they may have difficulty controlling themselves or acting in an expected manner. Three or four of the following symptoms must be present for an episode to be considered to be a manic phase: inflated (really high) self-esteem or grandiosity, decreased need for sleep, more talkative than usual or pressure to keep talking, racing thoughts, distractibility, increase in goal-directed activity, excessive involvement in pleasurable activities that have a potential for painful or negative consequences, such as spending sprees or gambling. A manic phase often requires hospitalisation for treatment. It can be effectively treated with medications plus other therapies.

Medication: is another word for medicine and is in most cases prescribed by a medical doctor. Medications are regulated by government authorities. There are many different classes of medications that are used to treat mental disorders (such as: antidepressants, antipsychotics, anti-anxiety). Medications can also be used to treat specific symptoms that are part of a disorder (such as: aggression).

Mental Disorder: is a disturbance of brain function that meets internationally accepted criteria (DSM or ICD) for a diagnosis. Mental disorders occur as a result of complex interaction between a person's genetic makeup and their environment. Many effective treatments (provided by health professionals) for mental disorders are available. Sometimes people use the term "mental health disorder" when they mean mental disorder. This is not necessary.

Mental Health: is a state of emotional, behavioural, and social wellbeing, not just the absence of a mental or behavioural disorder. It does not mean lack of distress. A person can have a mental disorder and mental health at the same time. For example: a person may have a Major Depressive Disorder that has been effectively treated and is still taking treatment for the disorder. Now they have mental health as well as a mental disorder.

Mental Health Issue: is a broad term used to describe mental distress, mental suffering or mental disorder. It is so broad that many researchers and health professionals think it is meaningless. We advise not using this term, but instead being clear about what you are talking about.

Mental Health Nurse (clinical nurse with a specialty in psychiatry): is a registered nurse who specialises in the maintenance of mental health and the treatment of mental disorders. This type of nurse usually works directly with people in a clinical setting, such as in a hospital or community clinic. Mental health nurses have many skills used in the diagnosis and treatment of people with mental disorders.

Glossary

Mental Health Professional: is a broad category of health care workers who work to help other people improve their mental health or treat mental disorders. Examples are psychiatrists, clinical social workers, psychiatric nurses, psychologists, mental health counsellors, child and youth workers, etc. They have all received training in working with people who are living with a mental disorder.

Mental Health Promotion: these are activities that try to improve the mental health of people or try to reduce risk for the development of various mental health or social problems.

Mental Illness: refers to a range of brain disorders that affect mood, behaviour, and thought process. Mental illnesses are listed and defined in the DSM and the ICD. The terms mental illness and mental disorder are often used interchangeably.

Mental retardation: is the below average general mental functioning that can be first noticed during childhood and is associated with problems in adjusting to different environments. A diagnosis of mental retardation means that the person has shown to perform lower than average (compared to others their age) in two areas: measured intelligence (IQ) and an overall rating of the individual's level of performance in school, at work, at home and in the community.

Mood: is the ongoing inner emotional feeling experienced by a person.

Mood Disorders: are a group of mental disorders related to problems in how the brain controls emotions. A person with a mood disorder experiences an abnormal change in mood. These include: MDD, Bipolar Disorder, and Dysthymia.

Mood stabilisers: medicines used to help normalise mood. They are usually used to treat Bipolar Disorder. Some of these are: lithium, valproate, carbamazepine. Some of these medicines are also commonly used in the treatment of epilepsy.

Myelin: look under **Brain**.

Narcissistic: is a quality or trait of a person who interprets and regards everything in relation to their own self and not to other people. It is associated with an unrealistic and highly inflated self worth.

Negative symptoms: are symptoms of Schizophrenia that follow a lessening of executive functioning (conscious choice, intention, decision making; problem solving) in the brain. The person either has less of something (for example energy) or is unable to do something (for example, unable to get out of bed). These symptoms include: inertia (inability to get one's self going), lack of energy, lack of interaction with their friends and family members, poverty of thought (significantly fewer thoughts), social withdrawal, and blunted affect (less emotionally responsive).

Neurodevelopment: is how the brain grows and changes over time.

Neuron (nerve cell): is a unique type of cell found in the brain and the spinal cord that processes and transmits information within the nervous system.

Neuroscience: is the scientific study of the brain and the nervous system.

Neurotransmission: is the process that occurs when a neuron releases special chemicals called neurotransmitters that relay a signal to another neuron across the synapse (a gap between parts of nerve cells).

Glossary

Neurotransmitters: are chemicals used to communicate messages that are being sent from one brain cell to another in the spaces between those cells. When the production, release, or uptake of any of these chemicals (neuron) is impaired the brain may show problems in how it is working. Some examples of neurotransmitters are: dopamine, serotonin, noradrenalin, etc.

Obsessions: are repetitive, persistent, unwanted thoughts that the person cannot stop and which cause significant distress and impair the person's ability to function. Mild and occasional obsessive thoughts are normal, but when they become severe and persistent they can be part of Obsessive Compulsive Disorder.

Obsessive Compulsive Disorder (OCD): is a type of mental disorder. People with Obsessive Compulsive Disorder experience persistent unwanted and recurring thoughts (obsessions) and/or persistent and unwanted repetitive behaviours (compulsions). Repetitive behaviours are carried out with the goal of preventing or getting rid of the obsessions or of releasing a strong feeling of inner tension. These behaviours may provide temporary relief for the person while not performing them can cause extreme anxiety. Examples of obsessions include repetitive thoughts of germs or contamination. Examples of compulsions include repetitive or excessive touching, counting, hand washing, and cleaning. OCD can be effectively treated with medications and psychological therapies.

Occupational Therapist: is a trained health professional that focuses on increasing a person's independent functioning, improving social skills, and preventing disability using self-care, employment, and recreational (fun) activities. For example, helping someone with a mental or physical disability develop job competencies or improve their daily living skills.

P.R.N. (as needed): is a Latin abbreviation used for prescriptions. Pro re nata translates to: when necessary.

Panic Attack: is a sudden experience of intense fear or psychological and physical discomfort that develops for no apparent reason and that includes physical symptoms such as dizziness, trembling, sweating, difficulty breathing or increased heart rate. Occasional panic attacks are normal. If they become persistent and severe, the person can develop a Panic Disorder.

Panic Disorder: is a mental disorder. A person with Panic Disorder has panic attacks, expects and fears the attacks and avoids going to places where escape may be difficult if a panic attack happens. Sometimes people with Panic Disorder can develop Agoraphobia. Panic Disorder can be effectively treated with psychological therapies or medications.

Patient advocate: is a person who helps a patient (or a patient's family) with problems and complaints in relation to care or help that they are getting from any agency or institution (hospital, clinic, psychiatric clinic, etc.). Patient advocates can speak on behalf of the patient (or family) and can often be helpful during times of disagreement between the patient (or family) and health care professionals. Many hospitals employ people who act as patient advocates.

Perception: is the mental process of becoming aware of or recognizing information that comes from the five senses: sight, sound, smell, touch or taste. Proprioception (knowing where your body parts are without looking) is also a type of perception.

Personality Disorders: is a general term for a group of behavioural disorders characterised by lifelong behaviour patterns. People with Personality Disorders don't adjust or function well in changing social environments. Signs of these patterns may include poor judgment, emotional control, impulse control, relationship functioning, etc.

Glossary

Positive symptoms: are symptoms found in psychosis, often in Schizophrenia. They include hallucinations, delusions, loose associations (unclear connections between ideas or disorganised flow of conversation topics), ambivalence (wanting to act one way but act in a way that is opposite to that), or unstable or quickly changing emotions.

Positron Emission Tomography (PET) scan: a technique using radioactive substances for studying how the brain is working by measuring different chemicals involved in the brain's work.

Postsynaptic neuron: is the nerve cell (neuron) that receives messages from other neurons across a synapse.

Posttraumatic Stress Disorder (PTSD): This mental disorder can happen to people who experience a really scary, painful, or horrific event in which they felt scared or helpless and during which they were in danger of death or severe injury. People who develop PTSD will have flashback memories, or nightmares of the event and will avoid things that remind them of the event. For example, if a person was assaulted in a park they may be too fearful to go to parks and have to find new routes to work. PTSD can be effectively treated with psychological interventions or medications.

Presynaptic neuron: is the nerve cell (neuron) that sends messages to other neurons across a synapse.

Prognosis: is an educated guess, based on previous evidence and scientific study, of how the disorder will affect the person over time. Your health provider will estimate the length of time the disorder will be present and how it may affect you. A prognosis can change over time. For example, if a treatment is very helpful then the prognosis may improve.

Protective factor: is anything that decreases a person's chances of getting a disorder or having a negative outcome. Protective factors can be aspects of a person's health, lifestyle or environment, such as a supportive family or community. Their actual effect in any one person is not easy to predict and it is not clear if they all actually have a direct effect or are just examples taken from healthy people compared to people who are not well.

Psychiatrist: is a doctor who specialises in the practice of psychiatry (the treatment of people who have a mental disorder and the prevention of mental disorders). Psychiatrists are medical doctors who have had many years of additional training in psychiatric medicine.

Psychiatry: is the medical specialty focused on understanding, diagnosing and treating mental disorders.

Psychologist: is a Ph.D level specialist in psychology licensed to practice professional psychology (e.g. clinical psychology), or qualified to teach psychology as a discipline (academic psychology), or whose scientific specialty is a subfield of psychology (research psychology).

Psychomotor: describes the mental process that helps put physical movements into action. For example, a feeling of fatigue may lead to walking very slowly or resting on a couch.

Psychomotor agitation: are movements that happen because of mental tension. It is often described as a way of relieving mental tension. For example, pacing back and forth and peeling or biting skin around fingers.

Psychomotor retardation: are slow thoughts as well as movements that are slowed down.

Glossary

Psychosis: is a mental state in which a person has lost the ability to recognise reality. Symptoms can vary from person to person but may include changes in thinking patterns, delusions, hallucinations, changes in mood, or difficulty completing everyday tasks (like bathing or shopping). Mental disorders such as Schizophrenia can include psychosis as a symptom. Psychosis can be effectively treated with medications and other additional treatments.

Psychotherapy: is a type of treatment for emotional, behavioural, personality, and other psychiatric disorders based mainly on person to person communication. Psychotherapies can be evidence-based (supported by many good research studies) or non-evidence-based (not supported by many good research studies). It is important for a patient to know what the evidence to support the psychotherapy that they are being treated with is. To find out more about any psychotherapy, check out the Evidence Based Medicine booklet at: www.teenmentalhealth.org.

Receptor: is a special part of a neuron where different chemicals from other neurons (neurotransmitters) or medicines attach. This leads to messages going between neurons being sent or blocked.

Recovery: is when a person with a mental disorder is doing as well as they can be and is feeling mentally healthy – even if they still have a mental disorder.

Recreation Therapist: is a professional that is trained in the specific area of therapy that uses recreational and leisure methods, such as games and activities, to improve a person's physical, mental, emotional, and relationship functions.

Recreation Therapy: is a type of therapy that uses methods such as games and group activities to improve a person's physical, mental, emotional, and relationship functioning.

Relapse: is when a person with a mental disorder who has been in remission or recovery gets sick again.

Remission: is when a person's symptoms decrease and they return to their usual state after having an active phase of a disorder.

Research: is the in-depth study done on a topic to find an answer to a question (e.g. a study on what is the best treatment for Depression). There are many types of research approaches used (for example observational, analytical, experimental, theoretical, and applied). Not all research is of the same value. One type of research design called the Randomised Controlled Trial (RCT) is the gold standard for helping us find out what treatments work best.

Results: are the outcomes of a study that support or do not support what the researchers had thought. They are used to guide practice or support further research.

Risk factor: is anything that increases a person's chances of getting a disorder (can be aspects of a person's health, genetics, lifestyle or environment). Remember, risk factors increase a person's chances of getting a disorder – they do not cause the disorder. Risk factors can be weak or strong. So having a specific risk factor may or may not be important for the person.

Safety: is the potential of a treatment or therapy to lead to or cause serious negative effects.

Schizoaffective Disorder: is a psychotic disorder that has symptoms of both Schizophrenia and a major mood disorder. People with Schizoaffective disorder can be effectively treated with medications and other additional treatments.

Glossary

Schizophrenia: is a mental disorder that can usually be diagnosed between the ages of 15 and 25. People who have Schizophrenia experience delusions and hallucinations (psychotic symptoms) and many other problems that can make day to day living difficult. While Schizophrenia runs in families some people can get Schizophrenia without a family history of the disorder. Schizophrenia can be treated with medications and additional interventions that can improve the lives of people with the disorder.

Seasonal Affective Disorder (SAD): is a type of Major Depressive Disorder that usually happens to people only, or mostly, at certain times of year (for example: winter).

Selective Serotonin Reuptake Inhibitors (SSRIs): are a group of medications used to treat Depression. These medications work mainly in the serotonin system of the brain.

Self-Harm (or Self-Injury): is any injury that a person inflicts on themselves without the intent to die. Examples of self-harming behaviours include: burning or cutting following an emotionally upsetting event, burning or cutting as a method of manipulation or threat, burning or cutting as a way of solving a problem.

Separation Anxiety Disorder: is an Anxiety Disorder that can be diagnosed in children which makes it very hard for them to be away from their parent. People with Separation Anxiety Disorder can be helped with psychological treatments.

Serotonin: is a neurotransmitter that helps in regulating many different brain functions, including mood, anxiety and thinking.

Single Photon Emission Computed Tomography (SPECT): is a technique that is used to study how the brain is functioning.

Social: is the ability to interact with other people in ways that are commonly accepted and appropriate to the situation/culture.

Social Phobia (also known as Social Anxiety Disorder): is an Anxiety Disorder regarding the fear of having to be in social situations. A person with Social Anxiety Disorder also avoids the situations that make them feel anxious. Examples include, the fear of public speaking, the fear of going to a party because other people are “judging” them, performing in front of other people. People with Social Anxiety Disorder can be effectively treated with psychotherapy or medication.

Social Worker: is a professional who is educated to deal with social, emotional, and environmental problems that may be associated with a disorder or disability. Services provided by social workers may include case management (connecting patients with programs that meet their needs), counselling, human service management, social welfare policy analysis, and policy and practice development.

Sociopath (or psychopath): is a person with Antisocial Personality Disorder.

Sociopathy: are the behaviour patterns and personality traits a sociopath displays such as superficial (fake) charm, having a lack of remorse (doesn't feel badly/guilty about doing something wrong), and others.

Somatic: describes the physical body. For example: sore muscles, fatigue, and headache are all somatic (also known as physical) sensations.

Specific Phobia: is an Anxiety Disorder. A person with a specific phobia experiences fear in the presence of an object or situation, snakes, fear of heights, fear of the dark, etc. Specific phobias often do not need to be treated. If they do, behaviour therapy is usually used.

Glossary

St. John's Wort: is an herb that some people think can help treat Depression.

Stigma related to mental illness: is attaching negative qualities to mental disorders (for example, thinking people with a mental disorder are dangerous). Stigma is a strong force and is harmful in that it may keep people from speaking about their disorder, getting help, or receiving treatment. It can create a false image of what mental disorders are and may force people to limit their social interactions, work, education, or to not seek help if they have a mental disorder.

Stress: is the body's reaction when forces such as infections or toxins disrupt the body's normal physiological equilibrium (homeostasis). Psychological stress develops in response to when a person perceives a threat, real or imagined, and determines whether they have the skills or resources to cope with the perceived threat. Stress is necessary for learning how to adapt. Too much stress can lead to a variety of health problems.

Stimulants: are a group of medications that improve various aspects of brain function such as alertness, concentration, etc. They are often used to treat ADHD.

Substance abuse: is an unhealthy pattern of drug, alcohol or other chemical use that may lead to relationship, education, work, mental and/or physical problems.

Substance dependence: is a pattern of actions, physical, and mental symptoms that develop from abuse of a substance (drug). A person who has a substance dependency may develop tolerance to the substance's effects and may experience withdrawal symptoms when they stop using the substance. They crave the substance and engage in behaviour designed to access and use the substance – even if the behaviour or substance is harmful to them. A similar term is "Addiction".

Substitute decision maker: is a person who is given the authority to make care or treatment decisions on behalf of an involuntary patient. See Involuntary Treatment Act.

Suicidality: refers to any thoughts or actions associated with the desire or intent to die. We do not recommend using this term as it is so broad that it cannot convey clearly what a person means. For example: a passing thought about death or an attempt to die are both examples of suicidality.

Suicide: is death that occurs as a result of an action designed to end one's life.

Suicide attempt: a purposeful act with the intent to end one's life that does not cause death.

Suicidal ideation: refers to thoughts, images or fantasies of harming or killing oneself.

Suicidal intent: is the commitment and expectation of death by suicide (future tense: the person intends to take their life; past tense: the person intended to take their life).

Suicidal Plan: is the mentally created plan to attempt to end one's life

Supported decision making: is the process in which a vulnerable person is provided advice, support, and assistance by their support network so they can make and communicate their own decisions.

Symptom: is an occurrence of any type experienced by a person that differs from their normal in structure, behaviour, sensation, emotion or cognition that indicates illness or disease.

Synapse or synaptic space: is a space between neurons (nerve cells). Neurons release chemicals into this space that regulate how messages in the brain operate.

Glossary

Syndrome: is a collection of signs (what a person observes about another person) and symptoms (what a person experiences) that describes a disease.

Systematic Desensitization: is a type of psychological treatment which gradually introduces things that a person fears so that they gradually overcome their fears.

Teen mental health: is a teen's state of emotional and spiritual wellbeing and not just the absence of disease. Focusing to improve the mental health and ability of teens' academic, social, physical, and other functioning will, in turn, increase their ability to contribute to society in the short and long term in meaningful ways. It is based on the brain's ability to adapt.

Therapist: is a person who is professionally trained and/or skilled in the practice of a particular type of therapy.

Therapy: is the treatment of disease or disorder by any method.

Tolerance: is when a person becomes less responsive to a medication or other treatment over time.

Trauma: is any painful or damaging injury or event that harms a person's physical or mental health.

Treatment: medical, psychological, social or surgical management and care of a patient.

Trichotillomania: is a mental disorder. People with Trichotillomania pull out their hair over and over again leaving noticeable hair loss. The person usually experiences tension before pulling the hair or if they try to stop themselves from pulling the hair and feel either pleasure or relief when pulling the hair out. The location of the hair can be anywhere on the body but is commonly from the scalp, eyebrows and eyelashes. Psychological treatments and sometimes medications are usually used to help with this disorder.

Violence: is emotional, sexual and/or physical abuse towards someone, usually in an effort to gain power or control of another person or group of people.

Voluntary admission: is being admitted as a patient to a mental health unit for treatment (usually in a hospital) based on a person's agreement to be admitted.

Voluntary patient: is a person who stays in a psychiatric facility (usually a hospital) by their own consent or with the consent of the substitute decision maker.

Withdrawal: is a brain response to a sudden stopping of use of a medication or drug. Symptoms of withdrawal can include: nausea, chills, cramps, diarrhea, hallucinations, etc. Withdrawal often occurs in addiction / substance dependence but most people who experience it are not addicted. Another meaning of withdrawal is the self directed avoidance of social contact. This can be seen in some mental disorders such as: Depression, Schizophrenia, Panic Disorder, etc.

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Community Resources

Community Mental Health Resource List

The following mental health related resources are available in many communities. Find out the contact information for these resources in your community and distribute to pupils.

Childline – 08001111

A place a child or young person can talk to someone about something they are worried about. They can do this online or over the phone. 08001111

NSPCC – 0808 8025544

This charity works against child abuse - a helpline is available for parents or other adults concerned about a child (0808 8025544).

Local Distress lines _____

Local Mental Health Organisations _____

Local Community Mental Health Clinic _____

Local Community Health Centre _____

Local Hospital _____

Website Resources

Further Information on Mental Health Problems and Mental Illness

National Centre for Mental Health (NCMH)

<https://www.ncmh.info/>

The NCMH website contains current and reliable information about a wide range of issues relating to mental health and illness across the lifespan.

National Health Service

www.nhs.uk

The NHS website contains up-to date and reliable information about a wide range of mental health disorders.

National Institute for Mental Health (NIMH)

www.nimh.nih.gov/

The NIMH website contains up-to date and reliable information about a wide range of issues relating to mental health and illness across the lifespan.

Royal College of Psychiatrists

<https://www.rcpsych.ac.uk/>

The RCP website contains a wide range of information on childhood and adolescent mental health and illness geared toward different audiences, including educators and parents.

Time to Change

<https://www.time-to-change.org.uk/>

Provides personal stories from young people about why mental health is important.

Time to Change Wales

<http://www.timetochangewales.org.uk/en/>

Time to change Wales is the first national campaign aimed at ending stigma and discrimination faced by people with mental health problems.

Teen Mental Health (Sun Life Financial Chair in Adolescent Mental Health IWK/Dalhousie University)

www.teenmentalhealth.org

Publications

Publications About The Guide

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